Utah Department of Health

OFFICE OF THE EXECUTIVE DIRECTOR

State of Utah

Michael O. Leavitt
Governor
Rod L. Betit
Executive Director
A. Richard Melton, Dr. P.H.
Deputy Director
Scott D. Williams, M.D., M.P.H.
Deputy Director

Martha Hughes Cannon Building
288 North 1460 West

Mailing Address:
Box 141000
Salt Lake City, Utah 84114-1000
(801) 538-6111, FAX (801) 538-6306

May 29,1998

Spencer K. Ericson
Associate Regional **Administrator**
Health Care Financing **Administration**
1961 Stout Street
Denver, CO 80294

Dear Mr. **Ericson:**

As requested in your **letter** of **May 21, 1998, we are enclosing** the clarifications and **revisions discussed** in our **State Children's Health Insurance Program** under **Title XXI** of **the Social Security Act,**

If **you have further questions** or **need additional** information, **please do** not **hesitate** to contact **me.**

Thank **you.**

Sincerely,

Rod L. **Betit**
Executive Director

Enclosures

STATE OF UTAH

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE
PROGRAM

DOH Response to HCFA May 5,1998 Questions
Revising the State Plan Submitted April I, 1998

Submitted by:

Rod L. Betit, Executive Director
Department of Health
May 30, 1998

DOH Response to HCFA May 5,1998 Questions

On April 2, 1908, the Governor and the Utah Department of Health submitted the plan for the Children's Health Insurance Plan (CHIP) for the state of Utah to the U.S. Health Care Financing Administration (HCFA). The information contained herein provides the response of the Utah Department of Health (DOH) to the fourteen (14) questions asked about the Utah CHIP by HCFA in their May 21, 1998 letter. The additional information requested is presented in the same format as that of the letter from HCFA.

Section 1.0 General Description and Purpose of the state Child Health Plan

Question 1: Please provide an assurance that the Title VII State Plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.

Response: The CHIP State Plan is revised on page 2 to read:

Section 1.0 General Description and Purpose of the state Child Health Plan

The state hereby makes the assurance that it will conduct the CHIP in accordance with all state and federal civil rights requirements.

Section 2.0 General Background and Description of State Approach to Child Health Coverage
Section 2.2.2

Question 2: Please describe in more detail the eligibility requirements for the Caring program. Will a child currently enrolled in the Caring program be eligible for CHIP?

Response: Section 2.2.2 of the CHIP State Plan is revised to include on page 11, at the end of ¶ 1, the following addition:

...the cost through private donations. ***Under the current Caring Program design, a child enrolled in the Caring Program will not be eligible for CHIP. The Caring Program, however, is currently considering significant changes to its program. If the Caring Program changes its program design and does not offer medical coverage that would substitute for CHIP coverage, Caring Program enrollees would be eligible for CHIP without a waiting period. The eligibility and enrollment requirements, services, cost, co-insurance and co-payments, deductibles are presented in Attachment C.***

Section 3.0 General Comments (sic) of State Child Health Plan
Section 3.1

Question 3: The state refers to "10% set aside funds" in this section and in Section 4.4.4. How is the state planning to use these administrative funds (10% of

federal and state funds) for nontraditional services to Indian children? Please include a description of these nontraditional services and the mechanism for service delivery.

Response: Section 3.1 of the CHIP State Plan is revised to include on page 15, at the end of ¶ 6 the following addition:

...defined by the community. *Eligible Indian children will be covered under the state plan and have full access to the benefits described when the plan becomes operational. The department has begun consultation meetings with Utah tribal leaders and tribal health directors to identify benefits based on culture that may be needed but are different than benefits for the general population. The objective is to identify methods used by the communities for assuring healthy children and include them in the benefits package. It is anticipated that the consultation process will be completed by July. At that time, the department will submit a State Plan amendment providing greater specifically.*

The 70% set aside funds will be used to provide these direct services to Indian children. For example: tribal health programs include community health representatives (CHRs) who are not usually covered under standard health benefits. CHRs play a vital role on reservations in providing home-based health education, minor treatments, monitoring and follow up services. Coverage would expand the accessibility of these services. Neither the tribes nor the Indian Health Service (IHS) is funded adequately to address the mental health needs of adolescents. Expanding the mental health benefits could be justified easily, given the teen suicide rate on reservations. In the areas where traditional healers are used, an arrangement for including them is an option.

The DOH will contract with each tribe as a CHIP provider for such direct services it can provide; and with the Indian Health Service as a provider for their services. Local non-tribal providers will be contracted with, if necessary, to provide the identified services.

Section 4.4.4 of the CHIP State Plan is revised to include on page 29, at the end of ¶ 2 the following addition:

...for eligible Indian children. *The DOH is currently in consultation with the Utah tribes to determine what nontraditional services should be covered. When this process is complete, the DOH will submit a plan amendment detailing the services to be covered. See Section 3.1, page 15 for more information.*

Question 4: The plan provides that health maintenance organizations (HMOs) contracting for

CHIP service delivery will use professional interpreters where technical, medical, or treatment information is discussed or "where use of a family member or friend as interpreter is inappropriate..." Page six of the Office of Civil Rights' Guidance Memorandum Title VI Prohibition Aaainst National Origin Discrimination- Persons with Limited English Proficiencv states that family or friends may only be used after a client has been informed that professional staff is available at no cost. The process herein does not meet this requirement. Please describe how the state will assure enrollees have access to translation services.

Response: The statement from page 15, ¶ 4, referenced by the HCFA reviewer was a direct quote from existing contract language, used to show the DOH intention in requiring providers to provide professional interpreters. In many instances, clients actually prefer that a family member or friend serves as the interpreter. The intention of the current contract language is to make certain that the most accurate technical, medical or treatment information is conveyed to the client. Future contract language for CHIP and the Medicaid program will be written to conform to all federal and state requirements.

Section 3.1 of the CHIP State Plan, page 14, is revised to include the following new paragraph immediately following paragraph 4:

Contracts with CHIP providers will specifically require the provision of professional interpreters at no cost to clients, whenever possible. Contract language for CHIP providers will specify that family members or friends may be used as interpreters at the request of the client, only after the client has been notified that professional interpreters are available at no cost. Clients will be provided information on interpreter services through program brochures, education by DOH eligibility workers and participating providers, PSAs, seminars, public health fairs, and any other means that the DOH will use in its extensive outreach efforts.

Section 4.0 Eligibility Standards and Methodology
Section 4.1.5

Question 5: n addition to the public laws listed in the plan, the state must include Public Law 104-208(501), (551), (552), (553) which amend Public Law 104-193 in order to include all federally mandated immigrants. However, we suggest that the plan be revised to state that Utah will follow all federal guidelines in determining whether a child is a United States citizen or a qualified alien. In this way, future legislative changes will be automatically included rather than having to amend this plan.

Response: Section 4.1.5(1) of the CHIP State Plan, page 21, line 19 is revised to read:

...alien as defined in Public Law 104-193 (401) through (403), (411), (412), (421) through (423), (431), and (435), as amended by *Public Law 104-208(501), (551), (552), (553)* and by Public Law 105-33(5302)(b) & (c), (5303), (5305)(b), (5306), (5562), (5563), and (5571).

Section 4.1.5(3) of the CHIP State Plan, page 21, line 30 is revised to read:

A qualified alien, as defined in Public Law104-193 (431) as amended by *Public Law 104-208(501), (551), (552), (553)*, and by Public Law 105-33(5302)(c)(3), (5562), and (5571), admitted into the United States prior to August 22, 1996, may receive Child Health Insurance Program benefits.

Section 4.1.5(4) of the CHIP State Plan, page 22, line 1 is revised to read:

...(431) as amended by *Public Law 104-208(501), (551), (552), (553)* and by Public Law 105-33(5302)(c)(3), (5562), and (5571), newly admitted into the United States on or after August 22,1996, may receive Child Health insurance Program benefits after five years have passed from the person's date of entry into the United States.

Section 4.1.5 of the Chip State Plan, page 22, is revised by adding the following paragraph *(5)* immediately after line *6:*

5. The state hereby further assures that the DOH will follow all federal laws and guidelines in determining whether a CHIP eligible child is classified as a citizen of the United States, or a qualified alien.

Section 4.1.7

Question 6: The plan states: "If a parent has access to health insurance at a premium equal to, or less than the CHIP premium, the child is ineligible for CHIP," This statement is inconsistent with the statement in Section 4.4.1 which states: "Any child found to have insurance coverage available...will be determined ineligible for CHIP." Please clarify.

Response: Section 4.1.7 of the CHIP State Plan, page 22, strike last ¶:

~~A child who is covered under a group health plan or under other health insurance coverage including coverage obtained through a parent's or legal guardian's employer, as defined by HIPAA, is ineligible for CHIP coverage. If a parent has access to health insurance through a parent's or legal guardian's employer, as defined by HIPAA, at a premium equal to, or less than, the CHIP premium, the child is ineligible for CHIP.~~

And substitute the following:

For purposes of this section "employer-sponsored plan" means a health benefit plan where the employer pays at least 50% of what it would cost to enroll the child.

If a child has health insurance coverage, the child is not eligible for CHIP enrollment. This includes coverage under a group health plan or other health insurance coverage as defined by HIPAA.

If a child has not enrolled but has access to coverage under a parent's or legal guardian's employer-sponsored plan, the child is not eligible for CHIP enrollment. If the child has access to coverage, except that the child must wait for an open enrollment period, the child may enroll in CHIP until the next open enrollment period begins. If the child is not enrolled during the next available open enrollment period, the child will be ineligible for CHIP enrollment for three months after the end of the open enrollment period.

If a child, parent of legal guardian, voluntarily terminates health insurance coverage for the child, the child is not eligible for CHIP enrollment for three months after the date such coverage was terminated.

If an absent parent is court-ordered to provide health insurance for a child and has access to an employer's health insurance plan, the child is not eligible for CHIP enrollment.

Section 4.4.3 of the CHIP State Plan, page 28, is revised by striking ¶ 6:

~~**Employer coverage** is defined for purposes of this section as an employer-sponsored health benefit plan where such employer contributes at least 50% of the cost of the employee's premium.~~

Question 7: According to Section 2110(b)(2)(B), the state may not provide coverage to a child of an employee of a public agency who has access to coverage under a state health benefit plan. Utah's State Plan Attachment D, HB 137, Section 16 states: "All employees of the state, its educational institutions, and political subdivisions are eligible to participate in this program...." Please clarify that the plan will comply with Title XXI.

Response: H.B. 137, Section 16, referenced in Attachment D to the CHIP State Plan, amends a section of Utah Code that regulates Utah's Public Employees Health Program (PEHP). This eligibility section pertains to PEHP enrollees, not CHIP enrollees. CHIP will not enroll a child of an employee

of a public agency who has access to coverage under a State health benefit plan.

This part of the code was included in H.B.137 to allow CHIP to use the PEHP if private managed care plans did not contract with CHIP to insure its enrollees.

Section 5.0 Outreach and Coordination
Section 5.1

Question 8; Given that most of the outreach initiatives are broad-based, rather than targeted, the state may have difficulty determining which, if any, areas are not being sewed, for example, in tribal and rural areas. Please explain how the state will determine the effectiveness of its outreach areas.

Response: Section 5.1 of the CHIP State Plan, page 36, is revised to add the following as a paragraph immediately after line 3:

...on eligibility for CHIP,

The effectiveness of the outreach efforts will be assessed by tracking the following indicators:

1) *Calls to the hotline, stratified by geographic location.*

2) *Postcards received by DOH requesting more information, stratified by point of distribution (schools, doctor's office, etc.) and geographic location.*

3) *Applications submitted for eligibility determination, stratified by geographic location.*

4) *Periodic assessments (every 7-2 years) of the ratio of number of eligibles and number served in geographic areas, to the population in such geographic areas.*

5) *Periodic (every 1-2 years) surveys of the volume of uninsured children seeking services in hospitals, emergency rooms, tribal and community clinics, etc.*

6) *Periodic (evety 3-5 years) statewide health status survey of the insurance coverage of children.*

Section 6.0 Coverage Requirements for Children's Health Insurance
Section 6.12

Question 9: The actuarial report does not provide sufficient information to determine if the

plan's benefit package meet the legislative requirements related to 75 percent of the benchmark for prescriptions, mental health, vision and hearing. Please provide actuarial certification that these legislative requirements as stated in Section 2103(a)(2)(C) are met. In addition, please provide a description of the benchmark plan, Public Employees Health Plan.

Response: The requested actuarial certification is appended to this document as Attachment A. Attachment C of the CHIP State Plan, the Actuarial Certification, is revised by including the requested certification immediately following page 111 in Attachment C of the Plan.

The description of the requested benchmark plan, Public Employees Health Plan "Preferred Medical Care" is included as Attachment D of this response.

Section 8.0 Cost Sharing and Payment

Section 8.2.3

Question 10: The state is inconsistent in defining income groups for cost-sharing. Section 6 refers to enrollees between 100% and 150% of FPL and between 151% and 200% of the FPL. Section 8 and Attachment B refer to enrollees above 100% of FPL and above 150% of FPL

Response: Section 6.2.1, page 38, line 18 is revised to read:

For enrollees befween 151% *and 200% of the* federal poverty level.

Section **8.2.3, page** 64, line 19 is revised to read:

Co-Payment Requirements for CHIP clients/enrollees between 100% and 750% of the federal poverty level

Section 8.2.3, page 65, line 12 is revised to read:

Co-Insurance and Co-Payment Requirements for CHIP clients/enrollees befween 151% and 200% of the federal poverty level

Attachment B: Benefit Plan, page 93, line 3 is revised to read:

for **CHIP** enrollees befween 100% and *150%* of the federal poverty level.

Attachment B: Benefit Plan, page 93, line 19 is revised to read:

for CHIP **enrollees** ***between*** 151% ***and 200%*** of the federal poverty **level.**

Question 11: The copayments for children at or below 150% of the Federal Poverty Level (FPL) listed below exceed federal requirements for copayments.

- The state provides for a $5 copayment for enrollees at or below 150% of FPL for

outpatient visits, In fee-for-service areas, the copayment must be limited to an amount considered to be nominal. A nominal copayment of $5 would apply to services over $80. In managed care areas, the $5 copay is an acceptable amount.

Response: The copayment of $5 for outpatients visits does not exceed federal requirements for copayrnents. The chart appended to this document as Attachment B gives the average of office visits for several services, all clearly over the $80 amount referenced in the question.

- The state provides for a $10 copayment for emergency room services for enrollees at or below 150% of FPL. A state may charge only a nominal copayment for an emergent visit to an emergency room. A state may charge twice the nominal amount for a non-emergent visit to an emergency room.

Response: Section 6.2.1, page 38 is revised by deleting line 17:

~~$10.00 co-payment for each emergency department visit.~~

Section 6.2.2., page 39, line 13 is revised to read:

$5 co-payment for each emergency room visit for *emergent reasons* ~~($5 for physician services and $5 for hospital services.~~

And adding the following line immediately after line 13:

$70 co-payment for each emergency room visit for non-emergent reasons.

Section 8.2.3, page 64, line 23 is revised to read:

$5 co-payment for each emergency room visit *for emergent reasons* ~~($5 for physician services and $5 for hospital services.~~

And adding the following line immediately after line 23:

$10 co-payment for each emergency room visit for non-emergent reasons.

Attachment B; Benefit Plan, page 93, line 5 is revised to read:

$5 co-payment for each emergency room visit for *emergent reasons* ~~($5 for physician services and $5 for hospital services.~~

And adding the following line immediately after line 5:

$70 co-payment foreach emergency room visit fornon-emergent reasons.

In addition, Section 6.2.6 of the CHIP State Plan is revised by striking line 1, and 3 through 6, page 44:

~~$1.00 co-pay per prescription.~~

For enrollees between 151% and 200% of the federa poverty level:

~~$1.00 co-pay per prescription for generic drugs and brand name drugs on an approved list.~~

~~Coinsurance, 50% of the allowed amount for brand name drugs not on an approved list.~~

And replacing them with:

$2 co-pay for generics and brand name drugs on the approved list.
$2 co-pay for brand name drugs not on approved list.

Note; a prior authorization will be required to use brand name drugs not on the approved list.

For enrollees between 151% and 200% of the federal poverty level:

$4 co-pay forgenerics and brand name drugs on the approved list.
50% co-insurance for brand name drugs not on approved list.

Note: a prior authorization will be required to use brand name drugs not on the approved list.

Section 8.2 of the CHIP State Plan is revised by striking line 4 on page 65:

~~$1.00 co-payment per prescription.~~

And replacing it with:

$2 co-pay forgenerics and brand name drugs on the approved list
$2 co-pay forbrand name drugs not on approved list.

Note: a prior authorization will be required to use brand name drugs not on the approved list.

Section 8.2 of the CHIP State Plan is further revised by striking lines 4 through 8 on page 66:

~~$1.00 co-payment per prescription for generic drugs and brand name drugs on an approved list.~~

~~Co-insurance, 50% of allowed amount for brand name drugs not on an approved list.~~

And , replacing them with:

***$4 co-pay for** generics and brand name drugs on the approved list.*
*50% co-insurance **for** brand name **drugs** not on approved list.*

*Note: a **prior** authorization will **be** required to use brand name drugs not **on** the approved list.*

Further, Attachment **B: Benefit** Plan of **the** CHIP **State Plan is revised by striking line 13 on page 93:**

~~$1.00 co-payment for prescription.~~

And replacing it with:

***$2 co-pay** for generics and brand name **drugs** on the **approved** list.*
*$2 **co-pay for** brand name drugs not **on** approved list.*

*Note: a prior authorization will be required to use brand **name drugs not** on the **approved list.***

Attachment B: Benefit **Plan of the** CHIP **State Plan is revised by striking lines 7 through 9 on page 94:**

~~For generic drugs and brand name drugs on an approved list: $1.00 co-payment per prescription~~

~~For brand name drugs not on an approved list: Co-insurance, 50% of allowed amount~~

And replacing them with:

***$4 co-pay for** generics and brand name **drugs on** the approved list.*
*50% co-insurance **for** brand name drugs not **on** approved list.*

*Note: a prior authorization will **be** required to use brand name drugs not on the approved list.*

Question 12: Please clarify coinsurance for dental services. The coinsurance information is Section 6.2.17 conflicts with this section [8.2] and Attachment C. The state may not apply coinsurance to preventive and diagnostic dental services,

Response: Section 6.2.17 of the CHIP State Plan, page 52, is revised by striking line 2:

~~Coinsurance, 20% of allowed amount.~~

And replacing it with:

100% coverage for cleaning, oral exam and fluoride. 20% coinsurance for dental fillings.

Section 8.2.3 of the CHIP State Plan, page 66, is revised by striking lines 16 and 17:

~~Coinsurance for dental fillings, 20% of allowed amount.~~

And replacing it with:

700% coverage for cleaning, oral exam and fluoride. 20% coinsurance for dental fillings.

Attachment B: Benefit Plan of the CHIP State Plan, page 94, is revised by striking line 17:

~~For dental fillings: co-insurance, 20% of allowed amount.~~

And replacing it with:

700% coverage for cleaning, oral exam and fluoride. 20% coinsurance far dental fillings.

Section 8.5

Question 13: The state should have a mechanism in place to ensure that once a family reaches their 5% limit that the family may cease paying further copayments and coinsurance. Please provide a further explanation of how families will be informed of the limits of their financial liability.

How will the state ensure that families do not make payments beyond their out-of-pocket maximum?

Response: Section 8.5 of the CHIP State Plan, page 68 is revised by striking ¶ 8:

~~This information will include written requests for the families to inform the state whenever the 5% maximum is exceeded. The family will receive a refund in an amount equal to their excess payments.~~

And replace it with the following:

In the four urban Wasatch Front counties (Weber, Davis, Salt Lake and Utah

counties), medical services will be administered through contracting managed care organizations (MCOs) such as HMOs or the Public Employees Health Plan (PEHP). Dental services will be administered by the Division of Health Care Financing (DHCF) in the Utah Department of Health (DOH).

Administration and monitoring of out-of-pocket expenses will be as follows:

1) The MCO or the PEHP will notify families of out-of-pocket expenses (co-payment and/or co-insurance) incurred for MCO covered medical services.

2) The DHCF will notify families of out-of-pocket expenses incurred for covered dental services.

3) The MCO or the PEHP will submit incurred out-of-pocket expenses to the DOH on behalf of their clients on a monthly or quarterly basis.

4) The MCO or the PEHP will notify the DOH when incurred out-of-pocket expenses exceed the $500 or $800 maximums.

5) The MCO, the PEHP and the DHCF will notify their providers when a family's out-of-pocket maximum has been reached.

6) The DOH will reimburse family's co-payment and/or co-insurance expenses in excess of the out-of-pocket maximum.

7) The DOH will provide a quarterly report to families on out-of-pocket expenses incurred. The DOH will consolidate information from the MCO, !he PEHP and the DHCF.

In the other counties, designated as rural, the DHCF will administer both medical and dental services.

1) The DHCF will notify families of out-of-pocket expenses incurred for covered medical and dental services.

2) The DHCF will notify their providers when a family's out-of-pocket maximum has been reached,

3) The DHCF will notify the DOH when incurred out-of-pocket expenses are exceeded.

4) The DOH will reimburse family's co-payment and/or co-insurance expenses in excess of the out-of-pocket maximurn.

5) The DOH will provide a quarterly report to families on out-of-pocket

expenses incurred.

Section 9. Strategic Objectives and Performance Goals for the Plan Adrninistration
Section 9.3

Question 14: Utah plans to use the HEDIS Measurement *set* relevant to children and adolescents to evaluate performance measures for monogcd care organizations providing care for CHIP children. For those rural children who will receive health care under a fee for service plan, hnw will performance Le measured lo ensure a high quality of care to Utah CHIP children enrolled in fee for service plans?

Response: Section 9.3 *of* the CHIP State Plan is revised by inserting on page 73, on line 3, the following:

..mcasurcs indcpendsnt of HEDIS. ***The CHIP quality monitoring requirements will apply to all CHIP contractors.*** Collection of data relative to the Utah ....

Section 9.3 of the CHIP State Plan, page 73, is revised by striking lines 16 through 23:

~~A requirement for collection of HEDIS measures will be written into all HMO/MCO contracts for CHIP provision of services along the Wasatch Front, that is, the urban areas of the State. For the rural areas of Utah, wherein individual physicians are likely to be the designated CHIP providers through fee-for-service contracts, the mechanism for collecting HEDIS measures is not yet well established. However, it is anticipated that such a mechanism will be developed by the end of the first year of CHIP implementation, and that client encounter data will be made available by rural providers for review by CHIP administrative and quality assurance staff.~~

And inserting immediately following the first sentence, the following paragraphs:

A requirement *for* collection of HEDIS measures will be written into all HMO/MCO contracts for CHIP provision of services along the Wasatch Front, that is, the urban areas of the State.

The CHIP administration will assume oversight responsibilities for quality assurance oversight of rural CHIP clients enrolled in rural areas, , Data collection requirements will apply to all CHIP contractors. Special accommodations to encounter level data formats and CHIP-supported abstraction of essential aggregate performance measures may be instituted for rural contractors.

The managed care organizations in the urban areas will be responsible for implementing a comprehensive quality assurance plan. For rural clients enrolled in fee-for-service plans, the CHIP administration will assume responsibility for those activities, including:

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STATE OF UTAH

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE PROGRAM

DOH Response to HCFA May 5,1998 Questions Revising the State Plan Submitted April 1, 1998

Attachment A: Actuarial Supporting Document

Submitted by:
Rod L. Betit, Executive Director
Department of Health
May 30, 1998

JOAN OGDEN ACTUARIES

Health Care Consulting

515 South 700 East. Suite 2B-1
Salt Lake City, Utah 84102

(801) 328-1717
FAX (801) 328-1741

May 22, 1998

Mr. Rod L. Betit
Executive Director
Utah Department of Health

DELIVERED BY HAND

SUBJECT: ADDITIONAL CERTIFICATION STATEMENTS PER THE DHHS REQUEST

Dear Rod:

I have reviewed the question #1 from the May 21, 1998, letter from DHHS. The following certification shoulcl meet the need:

> CERTIFICATION: I, Joan P. Ogden, principal of Joan Ogden Actuaries, am a member of the American Academy of Actuaries. I have been retained by the Department of Health of the State of Utah for the evaluation of and rating for the Children's Health Insurance Plan.
>
> I certify that the actuarial value of the benefits for prescription drugs, mental health coverage and vision and hearing services meet or exceed the actuarial value of coverage of the benchmark benefit package.
>
> - The actuarial value of the benefits for prescription drugs is greater than the actuarial benefit value for the benchmark plan, which has coinsurance payments of 10% for generic drugs and 20% for brand name drugs.
> - The actuarial value of the mental health coverage is identical with the actuarial value for the benchmark plan, since the two coverages are identical.
> - The actuarial value of the vision and hearing services coverage in the CHIP exceeds the actuarial value of the same services under the benchmark plan, since that plan has no such benefits covered.
>
> Joan P. Ogden, QHA, FCA, MAAA
> Consulting Actuary
> Joan Ogden Actuaries
> 515 South 700 East, Suite 2B-1
> Salt Lake City, Utah 84102
> (801) 328-1717

Please feel free to contact me with any questions or for any further information.

Sincerely,

Joan P. Ogden, QHA, FCA, MAAA
Consulting Actuary

STATE OF UTAH

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE PROGRAM

DOH Response to HCFA May 5,1998 Questions
Revising the State Plan Submitted April I , 1998

Attachment B: Average Costs for Office Visits

Submitted by:
Rod L. Betit, Executive Director
Department of Health
May 30, 1998

Summary of Office Visit Costs

DESCRIPTION	ENCOUNTER VISITS	MEDICAID PAYMENT	MEDICAID % OF CHARGES	EST. CHIP 80% CHARGES	CHIP PER UNIT
PHYSICIAN RELATED (a)	284,641	$ 20,338,574	0.47	$ 34,618,849	$ 122
MENTAL HEALTH	28,258	$ 7,237,296	0.95	$ 6,094,565	$ 216
PHYSICAL THERAPY	3,527	$ 168,496	0.35	$ 385,134	$ 109
SPEECH AND HEARING	2,219	$ 256,910	0.63	$ 326,235	$ 147
TOTAL	318,645	28,001,276	0.68	$ 41,424,783	$ 130
PHARMACY (b)	1,754,763	$ 51,918,273			$ 30
NOTES:					
(a) Physician includes: medical doctors, osteopaths, podiatrists, FQHC, psychologists, and chiropractors					
(b) Pharmacy costs are average payment per prescription					
SOURCE:					
MR-26 report for 7/1/97-4/30/98					
Counts by Primary Diagnosis Report FY 1997					

STATE OF UTAH

STATE PLAN
FOR
CHILDREN'S HEALTH INSURANCE PROGRAM

DOH Response to HCFA May 5,1998 Questions
Revising the State Plan Submitted April 1, 1998

Attachment C: Caring Program Details

Submitted by:
Rod L. Betit, Executive Director
Department of Health
May 30, 1998

Caring Program for Children SM
P.O. Box 25185
Salt Lake City, UT 84125-0185

Fred M. Rogers
Honorary Chairperson
Creator of *Mister Rogers' Neighborhood*

CARING PROGRAM FOR CHILDREN BENEFIT SUMMARY

Purpose:

Provide health insurance benefits for basic preventive and primary health care for uninsured children at no cost to the families.

Sponsored and Administered by:

Blue Cross and Blue Shield of Utah

Eligibility Requirements:

- ★ Unmarried child/children
- ★ Natural child/children
- ★ Legally adopted child/children for whom you are the courts appointed legal guardian.
- ★ Family income meets the required income guidelines *of* the Caring Program for Children.
- ★ Child/children 0 - 19 years of age
- ★ A resident *of* Utah
- ★ Enrolled in school through grade 12 (if of school age
- ★ Not eligible for Medicaid

Enrollment Requirements:

- ★ Must complete an enrollment application for each child applying
- ★ Must fall under set income guideline due to family size
- ★ Must provide proof *of* income (i.e. pay check stubs, social security disability income, unemployment income, child support)
- ★ Must provide current years income taxes and W-2 forms
- ★ Must provide a Medicaid denial letter with application.

CARING PROGRAM FOR CHILDREN

A Blue Cross and Blue Shield of Utah health care program for children in need

Cost of Program:

* None

Deductible:

* None

Coinsurance:

* None

Co-Payment:

* None

Health Restrictions:

* None (no child will be denied coverage for health reasons)

Pre-existing Condition Waiting Period:

* None

Covered Services:

* Physician office visits for medical care
* Well-child exams (check-ups)
* Immunizations
* Outpatient emergency
* Accidental Injuries
* Outpatient surgery, anesthesia, diagnostic services (pre-authorization required)

Non-Covered Services:

* Inpatient hospitalization and professional services
* Prescription drugs*
* Dental services
* Maternity care
* Cosmetic surgery and related services
* Ambulance services (unless life threatening)
* Psychiatric services and/or Psychological testing
* Allergy testing and injections

Health Care Providers:

Enrolled children may obtain covered medical care from any appropriately licensed health care provider. However, families are encouraged to see physicians, hospitals and other health care providers who participate with Blue Cross and Blue Shield (BCBSU).

* BCBSU **has** arranged with some pharmacies, (Smiths, Albertsons *of* Park City, Anderson Drug *of* Ephriam, San Juan Pharmacy of Monticello, Beaver Drug, K-Mart of Richfield & Cedar City, Davis IGA of Roosevelt, etc.) for a 10% discount, for enrolled families. Example of some drugs eligible *for* discount: Amoxicillin, Prednisone Tabs, Ibuprofen Pediatric Suspension and Fluoride Chewable Tabs.

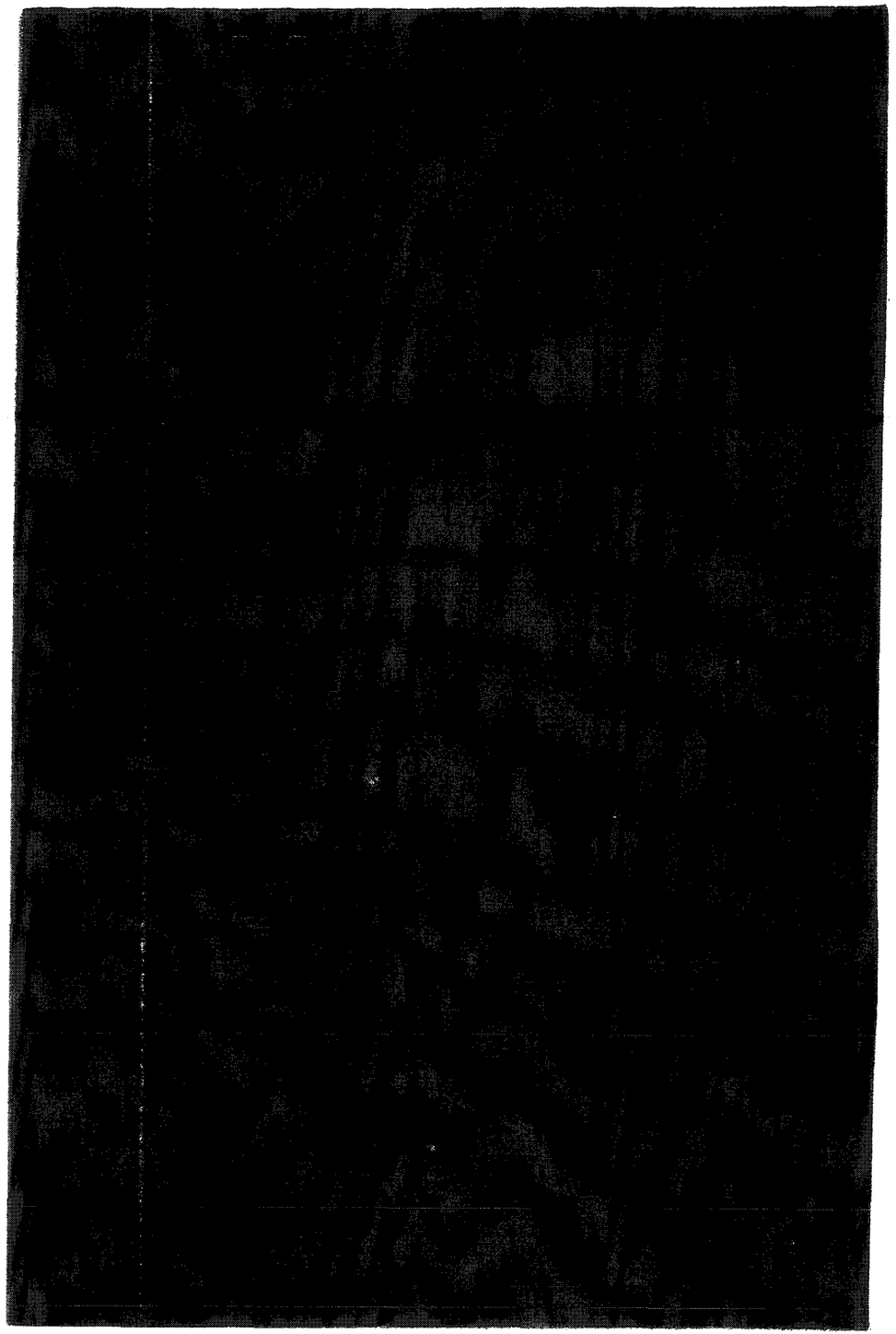
STATE OF UTAH

STATE PLAN FOR CHILDREN'S HEALTH INSURANCE PROGRAM

DOH Response to HCFA May 5,1998 Questions Revising the State Plan Submitted April 1, 1998

Attachment D: Benchmark Plan, Public Employees Health Program – Preferred Medical Care

Submitted by:
Rod L. Betit, Executive Director
Department of Health
May 30, 1998



1997-1998

medical benefits

Traditional Medical Care

Preferred Medical Care

UTAH RETIREMENT SYSTEMS

M. Dee Williams, Executive Director

Public Employees Health Program

Linn J. Baker, Director

David E. Lewis, Director Claims Division

R. Scott Hansen, Director Operations Division

Linda A. Parrish, Claims Department Manager

Donna Hansen, Claims Review Manager

Public Employees Health Program

560 East 200 South, Suite 100

Salt Lake City, Utah 84102-2004

Medical 801-366-7555 or

Toll Free 1-800-765-7347

Enrollment 801-366-7551

All Other Departments 801-366-7501

Public Employees Health Program

p e h p

Public Employees Health Program

TRADITIONAL CARE AND PREFERRED CARE PLANS

Effective July **1997**

Medical Benefits

This booklet is for informational purposes only and is intended to give a general overview of the benefits available under those sections of the Public Employees Health Program designated on the front cover. This booklet is not a legal document and does not create or address all of the benefits or rights and obligations of the Public Employees Health Program. The Public Employees Health Program Master Policy which creates rights and obligations of the Public Employees Health Program and its insureds is available upon request from Public Employees Health Program. All questions concerning rights and obligations regarding the Public Employees Health Programs should be directed to the Public Employees Health Program.

The information in this book is distributed on an "as is" basis, without warranty. While every precaution has been taken in the preparation of this book, neither the authors nor the Public Employees Health Program shall incur any liability due to loss, or damage caused or alleged to be caused, directly or indirectly by the information contained in this book.

The information in this guide is intended as a service to members of PEHP. While this information may be copied and used for your personal benefit, it is not to be used for commercial gain.

The employing units participating with the Public Employees Health Plan ("PEHP") and/or the uran Local Governments Trust ("ULGT") are not agents of PEHP or ULGT and have no authority to represent or bind PEHP or ULGT.

general information

As a wise consumer of healthcare services, you can help protect your healthcare plan from waste and abuse. Your healthcare plan in turn will protect you from unexpected catastrophic medical expenses. It's a team effort.

● TRADITIONAL CARE

If you are enrolled in PEHP Traditional Care, you have all the advantages of a traditional program. You have the freedom to use any eligible provider. You also have the benefits of the Preferred Care system and the Designated Service Plan (DSP).

If you receive medical services outside the state of Utah, you will have benefits payable according to the Public Employees Schedule of Benefits (PESB). You will be responsible for any remaining amount of the claim.

▲ PREFERRED CARE

If you are enrolled in Preferred Care, you have lower copayments and a reduced premium. We select quality providers who have proven records of efficient care and who will accept our fee schedules. Preferred Care requests that you pay your copayment at the time of service and the balance will be paid by PEHP. You will not have to submit a claim form.

Generally, when a non-preferred provider is used, Preferred Care will pay the Preferred Care Fee (PCF) minus your usual copayment. You will be responsible for the balance. This also applies to Hospital Emergency Rooms. However, if you are enrolled in Preferred Care and receive emergency services at a non-preferred facility or from a non-preferred provider, and your condition is life threatening at the time of service, PEHP will pay up to the Public Employees Schedule of Benefits ("PESB"). If possible, you must contact PEHP within *48* hours of the service to be eligible for this benefit.

Under Preferred Care if you receive medical services outside the state of Utah, you will have benefits payable according to Utah Preferred Care Fees. You Will be responsible for the balance. In a medical emergency while temporarily outside the state of Utah or when medical services are not available in Utah, claims will be reviewed for an adjustment in rates consistent with those charged in the area of service.

General Information (continued)

DESIGNATED SERVICE PLAN (DSP)

If you are enrolled in any PEHP plan outlined in this booklet, your copayment can be reduced by 50% or more if the service, condition, or procedure is identified as a designated service and is rendered by a DSP provider at a DSP facility.

DSP provides a single global fee for all services relating to a specific procedure. The global fee includes the facility, provider, anesthesia, and specified diagnostic tests. The global fee and your copayment are pre-determined.

Not all services, conditions, or procedures are covered under the DSP. Procedures not performed exactly as listed in the *DSP* Consumer Guide will be paid under the normal PEHP benefit guidelines.

For more information on DSP, please read your DSP handbooks or call the PEHP Customer Service at **801-366-7555** or **1-800-765-7347.**

CLAIMS ADMINISTRATION

PEHP may, with consent given on the enrollment card, release to or obtain from any insurance company, medical care provider, organization, or person any information which PEHP considers necessary for adjudication of claims. You will be required to furnish to PEHP such information as may be needed.

Because PEHP will not always cover the entire cost of your medical care, read this booklet carefully so that you will thoroughly understand your healthcare benefits and limitations. Be sure to review the information about insured copayments and those services requiring pre-authorization. Contact *PEHP with any* questions since *this* booklet *is for* informational *purposes only* and *is* intended *to give* a general *overview of your* benefits.

Expenses must be incurred while you are enrolled with PEHP to be considered. The date the medical service is received will be the date medical expenses are incurred.

The Medical Review Board may request your medical records to review or have the records reviewed by qualified healthcare providers to audit claims for pre-existing illness, medical necessity, and appropriateness of services within the standard of care of the medical community. Only these types of services will be considered for payment.

If additional information is required to process claims for any family member, PEHP has the right to hold payment for claims for the entire family until requested or required information is received.

In some instances, PEHP may require that all services be pre-authorized through medical case management and a primary care physician to be eligible for benefits.

If payments made by PEHP with respect to eligible benefits total more than the maximum amount allowable according to the PESB or PCF or if payment is made in error, PEHP will have the right to recover such overpayment from you. You will have 30 days from the date you receive written notice of overpayment to make reimbursement or arrange for repayment. If you do not make these arrangements, PEHP will take any other action appropriate under the Master Policy to recover the overpayment, and your coverage will be canceled. It will be necessary for you to submit a new enrollment card in order to be reinstated and new coverage will be subject to the pre-existing condition and waiting period provisions of the plan.

MASTER POLICY

A master policy with a complete description of benefits is maintained by PEHP. Benefits are subject to change with each policy year. Employing **Groups** are provided with a copy of PEHR master policy.

PREFERRED PROVIDER LIABILITY

Providers listed as Preferred Providers with PEHP are not employees or agents of PEHP, and PEHP does not control the manner in which Preferred Providers provide professional services. PEHP will not be liable or responsible for claims of malpractice or professional negligence against Preferred Providers or any healthcare professional reimbursed under PEHP programs.

h s : it

A hospital is an excellent place to receive medical care. It is not an appropriate place to rest, have tests or receive minor medical care.

Inpatient

TRADITIONAL/PREFERRED CARE

Charges for medically necessary inpatient hospitalization (semi-private room, ICU, and eligible ancillaries) are payable at ***90%*** of PESB or PCF.

If your hospital stay is going to exceed ***5*** days, it will be your responsibility to notify PEHP. Failure to notify the office Will result in a ***$25*** deductible per day beyond the fifth day up to a ***$200*** maximum. Notification allows PEHP to involve medical case management to assist in coordinating an appropriate and cost effective treatment plan. This can also save you out-of-pocket expenses.

When coverage terminates during a hospital stay, it will be necessary to convert to a COBRA policy to continue coverage for the completion of the stay beyond the termination date.

ALL HOSP A A RELATED TO MENTAL HEALTH OR SUBSTANCE ABUSE MUST BE PRE-AUTHORIZED. PRE-AUTHORIZATION IS AVAILABLE ***24*** HOURS A DAY BY CALLING ***1-800-541-9432.*** FAILURE TO PRE-AUTHORIZE WILL RESULT IN DENIAL OF BENEFITS.

LIMITED HOSPITAL STAYS

Benefits payable for the following hospital stays will be limited to:

Vaginal Hysterectomy	3 days	any age
Abdominal Hysterectomy	***4*** days	age 0–19 years
	3 days	age ***20-49*** years
	4 days	age 50 and above
Cholecystectomy (gallbladder)	***3*** days	up to age ***64***
	4 days	age 65 and above
Cholecystectomy, with exploration of ducts	***5*** days	any age
Caesarean Section	**96** hours	any age
Maternity, normal delivery	***48*** hours	any age

LIMITATIONS

1. Benefits for an otherwise non-covered dental procedure performed in an outpatient surgical facility may be authorized for a patient who is three years of age or younger, or is at high risk due to other medical diagnosis (such as a heart condition).
2. Benefits for inpatient confinement or hospitalization in a rehabilitation unit are Limited to a lifetime maximum of $50,000. Insureds who meet their $50,000 lifetime maximum may be eligible for an additional $1,000 yearly benefit.
3. Inpatient occupational therapy to restore fine motor function lost due to acute brain trauma, spinal injury, amputation, and acute physically debilitating illness may be approved in conjunction with eligible rehabilitation. When approved, benefits are limited to a $5,000 lifetime maximum payable within the rehabilitation maximum.
4. The following procedures if approved, are payable at 50% of PESB or PCF
   a. Surgery for sleep disorders;
   b. Breast reduction;
   c. Blepharoplasty (eyelid surgery);
   d. Otoplasty (limited to children under 12 years of age);
   e. Mastectomy for gynecomastia;
   f. Removal of breast implants. (Limited to a $1,000 maximum for all services provided when medical records document signs and symptoms of leakage or disease. This is a one time benefit. No benefits are payable for further reconstruction or replacement of implants.)
5. PEHP may approve functional nasal surgery where there is obstruction of breathing. Any external surgery (rhinoplasty) which may be cosmetic is not eligible, except as a result of an accidental injury occurring in the preceding five years.
6. Take-home medications are payable at 70% of PESB or PCF.
7. Newborn nursery room charges are separate from the mother's claim; chitd must be enrolled to be eligible, except as payable through the DSP.
8. Acute emergency medical services for life threatening injury or illness as a result of suicide attempt or anorexia/bulimia are payable as a medical claim. Other services must be pre-authorized through the inpatient mental health benefits.

Hospital/Facility (continued)

Emergency Room Services

Hospital emergency rooms specialize in treating traumatic situations. They have little, if any, provisions for continued care and usually require waiting in line unless your situation is considered life threatening. Minor emergency centers treat minor emergencies and cost you and your healthcare plan less money.

TRADITIONAL/PREFERRED CARE

Hospital emergency room services require you to pay a $50 copayment. PEHP will pay the remaining balance according to PESB or PCF. When emergency room treatment is for services that result in an inpatient admission or surgery (requiring an operating room) within 24 hours, the $50 copayment is waived and benefits are paid at 90% of PESB or PCF.

Emergency room provider visits, whether billed on the hospital bill or separately, are payable at 100% of PESB or PCF after a $10 copayment. Under Traditional Care any balance after PEHR payment will be the insured's responsibility.

When enrolled in Preferred Care charges for services at a Non-preferred facility are paid at the Preferred Care Fee minus any copayments. You are responsible for any balance due.

Emergency room and Emergency room provider copayments do not apply to out-of-pocket expenses.

Hospital Diagnostic Testing

Don't enter the hospital inpatient for tests that can be done on an outpatient basis. Pre-admission tests can save you time and money.

TRADITIONAL CARE

Diagnostic laboratory and radiology services for pre-surgery or pre-hospitalization (within 30 days) and during an inpatient stay are payable at 90% of PESB; other services are payable at 70% of PESB. When a Preferred Care hospital is used, the Preferred Care benefit will apply.

PREFERRED CARE

Radiology services (under $100) and diagnostic laboratory for pre-surgery or pre-hospitalization will be payable at 100% of PCF; radiology services above $100 and during inpatient stays are payable at 90% of PCF.

Outpatient Surgical Facilities

Many times you can choose where to have your surgery. Perhaps you don't need to be admitted to the hospital. At an ambulatory surgical center you will reduce your copayments and save your healthcare plan money.

TRADITIONAL/PREFERRED CARE

Charges for eligible benefits in an accredited ambulatory surgical facility are payable at 90% of PESB or PCF.

A surgical suite or operating room fee in the provider's office is allowable at 90% of PESB or PCF, up to a maximum of $200 if medically necessary. You are responsible for any balance due.

When enrolled in Preferred Care services performed in a non-preferred facility are payable at the Preferred Care Fee, minus the Preferred Care copayments. You are responsible for any balance due.

SEE PAGE 39 FOR EXCLUSIONS.

surgery

Have surgery done as an outpatient whenever possible. A growing list of procedures can be performed in out patient settings. Outpatient procedures can save you and your healthcare plan money.

Physician Charges

TRADITIONAL/PREFERRED CARE

Surgical procedures may be performed in a provider's office, hospital, or free-standing ambulatory surgical facility.

Charges for eligible services are payable at 100% of the PESB or PCF for surgical services rendered in a hospital or ambulatory surgical facility. Office-based surgery will be paid at PESB or PCF after a $10 copayment per encounter. **When enrolled in Preferred Care charges for services performed by a non-preferred provider will be paid at the PCF, minus any copayments. You will be responsible for any balance due.**

Second Opinion and Surgical Review

In many cases you can decide whether to have surgery. You can easily learn if you really need surgery by getting a second surgeon's opinion.

TRADITIONAL/PREFERRED CARE

In an effort to assist you in making a more informed decision once surgery is recommended, we encourage you to seek a second opinion. The PEHP Preferred Care panel of providers is an excellent source to use when seeking a second opinion. Obtain available medical records, including x-rays, to take with you for the second opinion evaluation.

Charges for the second opinion (office consultation only) will be paid at 100% of PESB or PCF. Your provider must indicate charges are for a second opinion for a possible surgical procedure to obtain full benefits.

SURGERY PRE-AUTHORIZATION

The procedure for pre-authorization includes submitting written medical information describing the need and type of care requested to PEHP prior to the time of service. PEHP will then send you information approving or denying your request. Telephone requests for pre-authorization cannot be accepted.

Pre-authorizations are valid for six months from the date of approval, subject to your coverage remaining active and any policy benefit changes.

If services are performed before approval is obtained, your claim must be retrospectively reviewed before payment can be made, and you are at risk for non-covered services.

The following procedures **require written pre-authorization:**

1. Surgery involving the jaw.
2. Transplantation services may be approved in conjundion with bone marrow, cornea, heart, kidney, lung, stem cells and liver transplantation when certain criteria are met and after a nine-month waiting period as a continuously covered insured of PEHP, if applicable.
3. Surgery that may be partially or wholly cosmetic in nature (cosmetic surgery is ineligible).
4. Surgeries performed in conjunction with obesity surgery, e.g., a gastric by-pass and gallbladder procedure performed during the same hospital stay (obesity surgery is not payable).
5. Nasal surgery—PEHP may approve functional nasal surgery where there is obstruction of breathing. Any external surgery (rhinoplasty) which may be cosmetic is not eligible, except as a result of accidental injury occurring in the preceding five years.
6. Surgeries of the Temporomandibular Joint (TMJ/TMD).
7. Implantation of artificial devices.
8. The following procedures, if approved through written pre-authorization, are payable at 50% of PESB or PCF
   a. Surgery for sleep disorders:
   b. Breast reduction;
   c. Blepharoplasty (eyelid surgery);
   d. Otoplasty (limited to children under 12 years of age):
   e. Mastectomy for gynecomastia:
   f. Removal of breast implants (limited to a $1,000 maximum for all services provided). No benefits are payable for further reconstruction or replacement of implants.
9. New technologies.
10. Cochlear implants.

Surgery *(continued)*

LIMITATIONS

1. When an eligible surgical procedure is performed in conjunction with other ineligible surgery, benefits will be prorated and only eligible benefits will be payable per PESB or PCF. All procedures must be disclosed for proper adjudication.
2. Eligible treatment for infertility is payable at 50% of PESB or PCF. This includes any office visits, hospitalization or surgical procedures.
3. When medically necessary, assistant surgeon services are payable at 20% of PESB or PCF. When a physician's **or** nurse assistant **is used** in lieu of an assistant surgeon, benefits are payable at 10% of PESB or PCF.
4. If insured's coverage under PEHP terminates during a pregnancy, continued coverage through COBRA must be purchased to receive benefits for maternity-Maternity benefits are paid at time of delivery.
5. Multiple surgical procedures during the same operative session are payable at 100% of PESB or PCF for the primary procedure and 50% of PESB or PCF for all additional eligible procedures.

SEE PAGE 39 FOR EXCLUSIONS.

anesthesia

TRADITIONAL/PREFERRED CARE

Anesthesia charges are payable at 100% of PESB or PCF for eligible surgery. **When enrolled in Preferred Care services performed by a non-preferred provider are payable at the Preferred Care Fee, and you will be responsible for any balance due.**

LIMITATIONS

1. Anesthesia must be administered by a qualified practitioner other than the primary surgeon.
2. Anesthesia benefit will be limited to 50% of PESB or PCF in conjunction with a surgical procedure that is limited to 50% benefits.
3. When an eligible surgical procedure is performed in conjunction with other ineligible surgery, benefits will be prorated and only eligible services will be payable per PESB or PCF. All procedures must be disclosed for proper adjudication.

SEE PAGE *41* FOR EXCLUSIONS.

medical visits

You will reduce your chances of getting sick if you plan your healthcare with your provider. Your first step: Choose a provider you trust.

TRADITIONAL/PREFERRED CARE

Medical visits, including visits in the providefs office, hospital, or emergency room, are payable at 100% of PESB or PCF after a $10 copayment. Outpatient chemotherapy or radiation therapy charges are payable at 90% of PESB or PCF. Dialysis is payable at 90% of PESB or PCF subject to coordination with Medicare benefits. **When enrolled in Preferred Care charges for medical visits performed by a non-preferred provider will be paid at PCF, minus the Preferred Care copayment. You will be responsible for any balance due.**

LIMITATIONS

1. Only one medical, psychiatric, chiropractic, or physical therapy visit per day for the same diagnosis for any one insured is allowable. Same-day visits by a multi disciplinary team may be eligible.
2. After pre-authorization treatment for TMJ or TMD syndrome benefits are payable at 50% of PESB or PCF, with a lifetime maximum of $1000 (excluding surgery).
3. Acupuncture treatments are only eligible for the treatment of pain and are limited to 16 treatments per policy year.
4. Speech therapy by a qualified speech therapist to restore speech loss or correct an impairment is payable if due to:
   a. A congenital defect for which corrective surgery has been performed.
   b. An injury or sickness; i.e., head injury or Cerebral Vascular Accident/Stroke; except a mental, psychoneurotic, or personality disorder. Speech therapy following chronic *otitis* media is not considered eligible for coverage. Charges are not payable for educational purposes, slow development, or speech therapy which does not qualify within the criteria. Eligible benefits are payable at 100% of PESB or PCF after a $10 copayment per visit and are limited to a lifetime maximum of $2,500.

5. Additional charges for after hours and/or holidays are payable only when special consultation is medically necessary beyond normal business hours or on-call or shift work requirements.
6. Cardiac rehabilitation, phase 2, is payable following heart attack or surgery for up to 24 visits.
7. Pulmonary rehabilitation, phase 2, is payable as a result of chronic pulmonary disease or surgery for up to 24 visits.
8. For Traditional Care, allergy injections are payable at 100% of PESB after a $3 copayment; no copayment is required if a Preferred Provider is used. Charges for office visits are not payable in conjunction with allergy injections. (See DSP for allergy treatment.)
9. For Traditional Care, allergy serum is payable at 70% of PESB; when a Preferred Provider is used, there is a $10 copayment per vial. (See DSP for allergy treatment.)
10. Services in conjunction with diagnosing and treating infertility (excluding invito fertilization) are payable at 50% of PESB or PCF.
11. Chronic pain disorders or syndromes requiring repetitive analgesic injections and ongoing management (above five visits per year) will be payable under outpatient mental health benefits.

CHIROPRACTIC/PHYSICAL THERAPY

Up to 16 medical visits per policy year may be approved for Chiropractic visits (adjustments to the vertebral column). A "physician's initial report" is required for authorization of the number of eligible visits. Chiropractic visits are payable at 100% of PCF or PESB after a $10 copayment. **When enrolled in Preferred Care, charges for services performed by a non-preferred provider will be paid at PCF, minus the copayment, you will be responsible for any balance due.**

Up to 16 medical visits per policy year are allowable for physical therapy (for other than spinal therapy). This benefit may include occupational therapy for fine motor function. Medical necessity and progress must be documented. P.T. modalities in conjunction with foot/toe surgeries are not payable separately. Physical Therapy visits are payable at 100% of PESB or PCF after a $10 copayment. **When enrolled in Preferred Care, charges for services performed by a non-preferred provider will be paid at PCF, minus the copayment, you will be responsible for any balance due.**

SEE PAGE 41 FOR EXCLUSIONS.

diagnostic testing, x-ray, and lab

Make sure every test ordered is necessary. In this way you will be doing your part as a good consumer of healthcam.

TRADITIONAL CARE

Benefits for eligible laboratory, x-ray, MRI and ultrasound services are paid at 70% of PESB. Whenever you use a Preferred Provider, the Preferred Care payment applies.

Lab and x-ray immediately (within 30 days) prior to surgery and hospitalization are paid at 90% of PESB. Lab and x-ray in conjunction with office surgery are payable at 70% of PESB or with applicable Preferred Care copayments.

PREFERRED CARE

Medically necessary laboratory, x-ray, and ultrasound services *from* a Preferred Provider are payable at 100% of PESB for each test and each x-ray up to $100. There Will be a 10% copayment for each x-ray costing $100 or more. Eligible MRI's are payable at 80% of PCF.

Charges for lab/x-rays performed by a non-preferred provider will be paid at the Preferred Care Fee, minus the copayment. You will be responsible for any balance due.

PRE-AUTHORIZATION

1. Magnetic Resonance Imaging (MRI) services will require written pre-authorization for anything other than brain, spine, or major joint imaging.
2. Diagnostic genetic testing in the course of evaluating an insured for genetic or congenital disease may be pre-authorized. (Epidemiological and preventive genetic screening and counseling are ineligible.)

3. Magnetic Resonance Angiography (MRA) may be approved in lieu of conventional x-ray angiography.
4. RAST Testing for allergies require written pre-authorization and Will be approved only under the following conditions:
   a. Patient is under 4 or over 65;
   b. Severe generalized atopic dermatitis or eczema; or
   c. Marked dermographism, urticaria, or severe asthma.

LIMITATIONS

1. Services in conjunction with diagnosing and treating infertility (excluding invitro fertilization) are payable at 50% of PESB or PCF.
2. Upon approval, Magnetic Resonance Imaging (MRI) is payable at 70% of PESB under Traditional Care and 80% of PCF under Preferred Care.
3. TMJ/TMD benefits are payable at 50% of PESB or PCF up to a lifetime maximum of $1,000 (including all eligible services except surgery—see Surgery section).
4. Drug screening is only payable in conjunction with a diagnosis of substance abuse and applies to outpatient mental health limits. Routine drug screening is not a benefit.
5. Sleep studies are payable at 70% of PESB under Traditional Care and 80% of PCF under Preferred Care to a maximum of $1,200 in a three year period.
6. Upon approval, MRA benefits are payable at 70% of PESB under Traditional Care and 80% of PCF under Preferred Care.
7. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness.
8. When multiple Lab tests are necessary, benefits are payable in "panels" rather than individual codes whenever possible as determined by PEHP.

SEE PAGE 43 FOR EXCLUSIONS.

ambulance

By familiarizing yourself with your benefit plan, you will be better able to make correct decisions when you arefaced with an emergency.

TRADITIONAL/PREFERRED CARE

Benefits for eligible ambulance services, including air transport, are payable at 70% of PESB or PCF for Traditional Care and Preferred Care.

LIMITATIONS

1. Only ambulance senn'ces to transport to the nearest place of proper care in medical emergencies are eligible.
2. Benefits will be payable for air ambulance only in acute life threatening circumstances when the insured could not be safely transported by ground ambulance, and only to the nearestfacility where proper medical care is available. Benefits Will be paid at the same rate as ground transport in other cases or whichever is less.

SEE PAGE 43 FOR EXCLUSIONS.

home health and hospice care

There are several alternatives available if you need extended care after you are hospitalized. Ask your provider which services would be appropriate for you.

TRADITIONAL/PREFERRED CARE

When appropriate and in lieu of hospitalization, medically necessary skilled home health and hospice services and home I.V. therapy may be paid at 100% of PESB or PCF. **These services must be pre-authorized.**

Charges for eligible home health services performed by a non-preferred provider will be paid at PESB or PCF, minus any copayments. You will be responsible for any balance due.

AN Home Health Services must be pre-authorized.

LIMITATIONS

1. Home oxygen, bilirubin lights, Total Parenteral Nutrition (TPN), Total Enteral Nutrition (TEN) or services which are not in lieu of hospitalization are payable at 70% of PESB or 80% PCF.
2. Up to 16 physical/occupational therapy visits are covered with applicable $10 copayment per visit and are subject to outpatient physical therapy Limits.
3. A home visit by a LCSW is payable at 50% of PESB or PCF from outpatient mental health benefits, except as covered under hospice.

SEE PAGE 44 FOR EXCLUSIONS.

adoption

TRADITIONAL/PREFERRED CARE

If you adopt a child, you may be reimbursed up to 50% of the associated legal expenses for adoption up to a $2,000 maximum. In order to be eligible for this benefit, you must have been enrolled with PEHP for 3 months prior to the placement of the child. This benefit will not be paid until the adoption becomes final and proper documentation is submitted. At the time of placement, the child must be 6 months of age or younger. An extension of the age limitation of 6 months may be extended up to 12 months, with pre-authorization, for overseas adoption.

In addition, if you adopt a child, PEHP will cover the pre-natal and maternity expenses of the birth mother up to the amount PEHP would have paid as if the Insured had become pregnant, if the child is placed for adoption within thirty (30) days of the child's birth. In order to be eligible for this benefit, you must have been enrolled with PEHP for three (3) months prior to the placement of the child. This benefit will not be paid until the adoption becomes final and proper documentation is provided. If you change insurance policies after medical services have been rendered, PEHP will only be responsible for the expenses incurred while you are covered by PEHP. If the birth mother has medical insurance, PEHR coverage shall be secondary. Proper application and submission of documentation, including itemized medical bills must be submitted to be eligible for this benefit.

SEE PAGE 44 FOR EXCLUSIONS.

mental health

You may receive outpatient treatment at a psychiatric day treatment facility. Details are available 24 hours a day by calling 1-800-541-9432.

Mental Health Facility and Hospital Services

TRADITIONAL/PREFERRED CARE

Services from hospitals, inpatient treatment centers, and outpatient facilities must be pre-authorized (see Limitations). Pre-authorization is available *24* hours a day by calling *1-800-541-9432.* If approved, facility charges are payable at 90% of PESB or PCF for the first 10 days and 50% of PESB or PCF for the next 20 days for a maximum of **30** days per policy year, **60** days per **36** month period. Charges for the full hospital stay will be prorated to determine a per diem rate for adjudication of daily benefits. *Services for* Attention Deficit Disorder (ADD), eating disorders, and pain clinics are payable as mental health benefits.

For those enrolled in Preferred Care, charges for eligible mental health services performed by a non-preferred provider will be paid at PCF, minus any copayments. You will be responsible for any balance due.

Mental Health Inpatient Provider Visits

TRADITIONAL/PREFERRED CARE

Eligible hospital visits for authorized days are payable at 100% of PESB or PCF after a $10 copayment. If provider visits are included on the hospital bill, they will be included in the per diem proration for adjudication of daily benefits.

Mental Health (continued)

Mental Health
Outpatient Provider Visits

TRADITIONAL/PREFERRED CARE

Outpatient treatment by a licensed professional psychologist, clinical social worker, psychiatric nurse specialist, or medical provider is payable at 50% of PESB or PCF up to $1500 per policy year.

Mental health benefits include coverage for the following:

1. Attention Deficit Disorder (ADD).
2. Eating disorders.
3. Eligible psychological testing.
4. Eligible neuropsychological evaluations and testing.
5. Medical management to monitor use of psychotropic drugs.
6. Chronic pain disorders or syndrome requiring repetitive analgesic injections or on-going management.
7. Laboratory services or medical visits to monitor certain medications such as Clozaril for schizophrenia.
8. ICD-9 codes relating to mental health.

SEE PAGE 44 FOR EXCLUSIONS.

substance abuse

There are many excellent outpatient substance abuse progmms available in this area. You will have a reduced capayment when you use a DSP provider.

Substance Abuse
Facility and Hospital Services

TRADITIONAL/PREFERRED CARE

Services from hospitals, in-patient treatment centers, and outpatient facilities must be pre-authorized. Pre-authorization is available *24* hours a day by calling *1-800-541-9432*. If approved, benefits are payable at 90% of PESB or PCF for the first 10 days and 50% of PESB or PCF for the next 20 days for a maximum of 30 days in a 36-month period. Charges for the full hospital stay will be prorated to determine a per diem rate for adjudication of daily benefits.

For those enrolled in Preferred Care, charges for eligible substance abuse services performed by a non-preferred provider will be paid at PCF, minus any copayments. You will be responsible for any balance due.

Substance Abuse
Inpatient Provider Visits

TRADITIONAL/PREFERRED CARE

Eligible hospital visits for authorized days are payable at 100% of PESB or PCF after $10 copayment. If provider visits are included on the hospital bill, they will be included in the per diem proration for adjudication of daily benefits.

Substance Abuse
Outpatient Provider Visits

TRADITIONAL/PREFERRED CARE

Outpatient treatment by a licensed professional psychologist, clinical social worker, psychiatric nurse specialist, or medical provider is payable at 50% of PESB or PCF up to $1,500 per year.

Drug screening is only payable in conjunction with a diagnosis of substance abuse and applies to outpatient mental health limits. Routine drug screening is not a benefit.

SEE PAGE *44* FOR EXCLUSIONS.

medical supplies

Insurance plans are funded to pay for standard equipment. Shopping around for the best buy can save you and your healthcare plan money.

TRADITIONAL/PREFERRED CARE

Purchase or rental of eligible durable medical equipment (DME) such as crutches, wheelchairs, hospital beds, and similar equipment is payable at 70% of PESB under Traditional Care or 80% of PCF under Preferred Care. Eligible prosthetics and orthopedic braces are covered under this benefit. Any extended rental or purchase of medical equipment in excess of $500 will require written pre-authorization.

PEHP will allow the cost of standard equipment or supplies necessary to treat the medical condition. Additional charges for more elaborate or precision equipment or supplies will be your responsibility.

The total benefits allowable for rental and/or subsequent purchase may not exceed 70% of the purchase price of the equipment, plus 60 days rental.

LIMITATIONS

1. When an insured uses a non-preferred provider for durable medical supplies over $500, they must provide bids from three vendors. If the low bid is equal to or lower than PEHP Preferred Care Fees, benefits will be paid at the Preferred Care rate of 80% of PCF. Insured may elect to use the vendor with the higher charges, but benefits will be paid at 70% of PESB according to contract guidelines and any balance will be the insured's responsibility.

   Coverage is provided when the medical equipment is:
   a. medically necessary;
   b. prescribed by your provider and approved by PEHP;
   c. used for medical purposes rather than for convenience or comfort; and,
2. Machine rental or purchase for the treatment of sleep disorders is payable at 50% of PESB or PCF upon approval.

3. Some equipment purchases are limited to one in any five-year period.
4. PEHP will allow one lens for the affected eye following eligible corneal transplant surgery. Contact lenses for documented Keratoconus may be approved as medically necessary.
5. PEHP will allow one breast prosthesis for each affected breast and one bra following eligible mastectomy surgery.
6. PEHP will allow two pair support hose per policy year for phlebitis or other eligible diagnosis.
7. An ankle-foot orthosis (AFO) is payable in lieu of casting for a diagnosis such as multiple sclerosis or drop foot.
8. A muscle stimulator or TENS unit-may be approved for rental or purchase with written pre-authorization after a one-month trial period to determine benefit sustained from use. One-time purchase benefit only. No benefits are payable for maintenance or repair of this equipment. Benefits for a TENS unit and supplies are limited to a lifetime maximum of $500.
9. Orthopedic braces may be approved if medically necessary and physician-ordered. Braces which are only required for participation in sports are not eligible. No benefits are payable for replacement of lost braces.
10. Continuous passive motion (CPM) machine rentals may be approved on a limited basis. Routine use of CPM following toe/foot surgeries is not eligible, except when limited criteria is met. A benefit is eligible for an initial set up fee.
11. Artificial prosthetics, such as eyes, limbs, or breasts may be approved. Maximum prosthetic benefit available in any five-year period is $15,000, including all services and replacements.
12. Only conventional, body-powered, cable-operated prosthetics will be eligible for loss of a limb or congenitally missing limb(s). Additional charges for more elaborate or precision equipment will be the insured's responsibility.

SEE PAGE 45 FOR EXCLUSIONS.

prescription drug benefits

TRADITIONAL/PREFERRED CARE

Pharmacy benefits are provided through a self-funded drug card program. Only those insureds on which PEHP is primary carrier will be listed on the pharmacy card to assure accurate Coordination of Benefits.

You must present your prescription card to the pharmacist at the time the prescription is filled. You will then be required to sign a signature log and pay the copayment. When a Preferred Pharmacy is used, the copayment is 10% of the Average Wholesale Price (AWP) plus the pharmacy's dispensing fee on a generic drug and 15% of the AWP plus the pharmacy's dispensing fee on a name brand-drug. When a non-preferred pharmacy is used, the copayment is 20% of the AWP plus the pharmacy's dispensing fee for a generic drug and 25% of the AWP plus the pharmacy's dispensing fee for a name brand drug. The dispensing fee will be determined by the pharmacy. Prescription drugs purchased with the drug card are exempt from the nine-month waiting period. You may purchase up to a 100-day supply of maintenance drugs prescribed by a provider.

If PEHP is the secondary carrier, you must purchase the prescription and submit the claim to the primary insurance company, then submit an itemized receipt and the explanation of payment or denial from the primary insurance company. PEHP will then pay secondary benefits, not to exceed 80% of the Average Wholesale Price (AWP) for generic drugs and 75% of AWP for name-brand drugs.

For out-of-state prescription purchases, you must pay the total amount of the prescription, then submit an itemized receipt to PEHP for reimbursement. Eligible prescription drugs may be reimbursed at 80% AWP on generic drugs and 75% on name-brand drugs. If you do not use the Identification/Prescription card or if there is dual coverage (a combination of two or more PEHP plans), eligible prescription drugs may be reimbursed at 80% or 75% AWP as applicable, with an itemized receipt.

COVERED DRUGS

—Legend Drugs
—Insulin and diabetic supplies (except diabetic appliances)
—FDA approved drugs used for non-experimental indications
—Fluoride drops or pills (for patients under age 12)

LIMITATIONS

1. Eligible diabetic supplies, i.e., insulin, syringes, needles, etc. purchased at a pharmacy will be processed as a pharmacy claim. Purchases from other than a pharmacy will be processed as a pharmacy claim under the medical claim system payable at 70% of PESB or PCF, and the balance does not apply to out-of-pocket limits.
2. Only one glucometer will be payable in any five-year period.
3. Betaseron, Avonex, Copaxone and syringes for multiple sclerosis are payable as a medical benefit.
4. Pulmozyme for cystic fibrosis is payable as a medical benefit. More than one ample per day requires pre-authorization.
5. Growth hormones require written pre-authorization but will only be approved when medically necessary and not simply an adjunct to growth. It may be approved on a trial basis (3-6 months) to determine effectiveness. If approved, it is payable as a medical claim and is subject to progress reports and periodic review and authorization. It may not be purchased through the drug card system. Balance will not apply to out-of-pocket limits.
6. Oral Progesterone drugs will be paid at a variable rate.
7. Oral fertility drugs are payable at 50% AWP. Injectable fertility drugs may not be purchased through the drug card system, but may be submitted as a medical claim (excluding invitro fertilization) payable at 50% PESB. The balance will not apply to out-of-pocket limits.
8. Anti-rejection medications (Cyclosporine, Sandimmune) following an eligible organ transplant may be payable through the drug card system. Benefits are payable outside the maximum transplant limits.
9. Clozaril for schizophrenia requires written pre-authorization from a board certified psychiatrist and, if approved, will be payable at 75% AWP. Laboratory services will be processed as a mental health claim under PEHP. The balance Will not apply to out-of-pocket limits.

Prescription Drug Benefits (continued)

10. Injectable medications such as allergy serum, etc., may not be purchased through the drug card system, but may be submitted as a medical claim.
11. IV (intravenous) drugs may not be purchased through the drug card system, but may be payable as a medical claim after required pre-authorization.
12. Medications for smoking cessation (i.e. smoking patches) have a maximum benefit of $350 per year, as determined by ingredient cost. The patient will be responsible for a normal copayment until the dollar limit is reached. Any further costs will be the patient's responsibility. The benefits is administered on a yearly basis.
13. Every prescription must be filled individually, per person, with a separate copayment.
14. Prescriptions purchased in a foreign country are not be payable through the drug card system, but may be payable as a medical claim. Itemized receipts should include the American equivalent of the drug as well as the conversion of the charges into U.S. currency.
15. Brand-name drugs are payable at 75% AWP, regardless of whether a generic is available.
16. Cosmetic alteration drugs (Oxsoralen) requires written pre-authorization from a physician. If approved, it is payable at 75% AWP through the drug card system.
17. Injectable hormones cannot be purchased through the drug card system. The claim may be payable as a medical claim, subject to certain limitations.

SEE PAGE 46 FOR EXCLUSIONS.

out-of-pocket expenses

TRADITIONAL/PREFERRED CARE

All PEHP plans have set limits for maximum out-of-pocket expense for insureds. For eligible expenses incurred by you or your dependents in any policy year, after your share of expenses exceed:

$1,500 per person or
$2,000 per family,

PEHP will pay further eligible charges incurred during the remaining policy year at 100% of PESB or PCF.

EXCLUSIONS

1. The amount not covered because a non-preferred provider was used.
2. Charges paid by the insured for inpatient or outpatient mental health or substance abuse treatment.
3. Charges in excess of other maximums for mental health and substance abuse treatment or Clozaril.
4. Any service or amount established as ineligible under PEHP or considered inappropriate medical care.
5. Charges paid by the insured for TMJ/TMD treatment.
6. Pharmacy or prescription drug card copayments, including copayments for diabetic supplies.
7. Charges paid by the insured for sleep apnea testing, surgery, or equipment.
8. Charges paid by the insured for infertility testing, surgery, or equipment.
9. Charges paid by the insured for growth hormone therapy.
10. Charges in excess of plan limitations, PESB or PCF or lifetime maximum.
11. Charges paid by the insured as penalties for failing to pre-authorize.
12. Emergency room, facility and physician copayments.

enrollment

There is an enrollment time limit, so enroll yourself and your dependents as soon as possible.

ELIGIBILITY

If you are eligible for health insurance benefits under PEHP through your employer, you may enroll yourself and your dependents within 60 days from the date you are employed. If, prior to enrolling in PEHP, you have had health insurance coverage without a lapse in coverage of 63 days or more, your prior coverage may be used to reduce your nine month pre-existing condition exclusion period by the amount of time you were covered under your previous insurance coverage. When enrolling, PEHP will require a Certificate and Disclosure Statement. Without the Certificate and Disclosure Statement, new enrollees may be subject to the full nine month pre-existing condition exclusion period.

If, at the time of enrollment you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in PEHP, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after marriage, birth, adoption, or placement for adoption. Except for the circumstances described above, you may not enroll until the next annual enrollment period.

Coverage begins the day following the pay period from which the first premium deduction is made. If you are not working full-time on that date, coverage for you and your dependents will be delayed until you return to full-time work. Restrictions concerning pre-existing conditions apply to all new insureds, except newborns enrolled within 30 days of birth and/or adopted children enrolled within 30 days of placement. No pre-existing condition exclusion will be imposed on pregnancy.

During an eligible annual enrollment period, you may change from one agency-sponsored plan to another without being subject to a waiting period, provided there is no lapse in coverage of 63 days or more.

Any and all changes — such as enrolling a new spouse, deleting a spouse, adding a new dependent — MUST be done in writing and submitted to the PEHP Administrative Office by the insured. Changes made over the telephone are not acceptable.

DEPENDENT COVERAGE

The following dependents are eligible for coverage:

1. Your lawful spouse.
2. Unmarried children or stepchildren up to the age of 26 with whom you have a parental relationship.
3. Unmarried legally adopted children, foster children, and children through legal guardianship up to the age of 26 subject to PEHP receiving adequate legal documentation.
4. Unmarried children age 26 or older who are incapable of self-support because of a mental or physical handicap for as long as they remain incapacitated, subject to your continued coverage. ***Periodic medical documentation is required.***
5. Dependent children for whom you are required to provide health insurance as stipulated in a divorce decree. Your ex-spouse and/or stepchildren can no longer be covered under the group plan, but may be eligible to convert to a COBRA plan.

When enrolling a spouse or dependent child, you must inform PEHP of other medical insurance in force by completing the coordination of benefits section on the enrollment form. This information is vital for the proper order of coordination of benefits to be determined. If applicable, you will be required to submit court orders or decrees. (See Coordination of Benefits Section.)

IT IS YOUR RESPONSIBILITY TO NOTIFY THE PEHP ENROLLMENT DEPARTMENT WHEN A DEPENDENT IS NO LONGER ELIGIBLE. PEHP CANNOT REFUND PREMIUM PAYMENTS MADE FOR INELIGIBLE DEPENDENTS. YOU WILL ALSO BE REQUIRED TO REIMBURSE PEHP FOR ANY CLAIMS PAID ON YOUR DEPENDENTS THAT ARE NOT ELIGIBLE FOR COVERAGE.

FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

Consult your employer to determine if you are eligible to be granted unpaid leave under FMLA for any of the following reasons:

1. To care for your child after birth, placement of adoption, or placement of child for foster care:
2. To care for your spouse, child, or parent who has a serious health condition: or,
3. For a serious health condition that makes you unable to perform your job.

For the duration of FMLA leave, your employer must maintain your health coverage.

Enrollment (continued)

LEAVE OF ABSENCE/APPROVED SICK LEAVE

When you are on temporary leave of absence, your coverage can be maintained as outlined for a maximum period of six months.

In order to continue your coverage, you must remit the group premium directly to PEHP, 560 East 200 South, Salt Lake City, Utah 84102. You should estimate the length of time you will be off the payroll, and remit, in advance, enough premium to pay for your coverage during this period. If coverage is not continuous because you neglect to pay your premium within 30 days, your coverage will be canceled for nonpayment of premium. It Will be necessary for you to submit a new enrollment card when you return to work. You and your dependents will be subject to the waiting period provisions of the plan if there is a lapse in coverage of 63 days or more.

MILITARY LEAVE

If you are called to active duty in the military, you are excluded from coverage under PEHP's health programs. You will be automatically covered by the military health plan and may enroll your dependents if you serve at least 31 days. You also have the option of continuing coverage for up to 18 months under the provisions of the Uniformed Services Employment and Reemployment Act of 1994.

Coverage for your dependents who were covered under PEHP at the time of your activation may continue coverage at the group premium rate. It is your employer's option to continue paying all or a portion of the premium.

If you choose not to continue coverage for your dependents, coverage for you and your dependents can be reinstated within 90 days of your discharge. Proof of insurability will not be required, and the nine-month waiting period will be waived.

termination of coverage

When you terminate your coverage, you must notify PEHP and return your Identification/Prescription card.

TRADITIONAL/PREFERRED CARE

Coverage for you and your dependents will terminate if you voluntarily cancel your coverage in writing, discontinue paying premiums, are no longer eligible for benefits, or you or your dependents enter the armed forces. Coverage terminates at the end of the period from which the final payroll deduction of premium is taken. Termination dates can vary according to your employer's payroll practices.

It is your responsibility to notify PEHP when a dependent is no longer eligible for coverage. Premiums cannot be refunded for payments made for ineligible dependents. If PEHP is not notified in writing that a dependent is ineligible and subsequent claims are paid, you will be responsible to reimburse PEHP for any claims paid in error.

PEHP will have the right to terminate coverage if you or your dependents are found to be abusing or misusing benefits.

GROUP HEALTH CONTINUATION OF COVERAGE UNDER COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 "COBRA", requires that most employers sponsoring group health plans offer employees and their families the opportunity for temporary extension of healthcare coverage (called continuation of coverage) at an increased group rate where coverage would otherwise end.

If you, your spouse, and your dependent children are covered by PEHP, coverage can be continued under COBRA for any of the following reasons:

1. A termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment (18 months continuation of coverage, 29 months if disabled).
2. Your death (36 month continuation of coverage).
3. Divorce or legal separation (for your spouse and dependents) (36 month continuation of coverage).

Termination of Coverage *(continued)*

4. You become entitled to Medicare, and you are already on COBRA (36 month continuation of coverage).
5. Your dependent child ceases to be a "dependent child" under the definitions of the policy (36 month continuation of coverage).

The COBRA coverage Will be administered in accordance with Federal law.

Medicare Entitlement

If you become entitled to Medicare before or within 60 days after your qualifying event, your spouse and dependent children may receive extended COBRA coverage up to 36 months from the date of your qualifying event. Contact PEHP for details.

Disability Determination

If it is determined that you, or any of your dependents are disabled (for Social Security purposes) at or within 60 days after the time of the qualifying event, the 18-month period is extended to 29 months from the date of the qualifying event. This extension only applies if you notify PEHP in writing within 60 days of a disability and before the end of the initial 18 months of COBRA coverage.

Conversion

You and/or your dependents who are ineligible under the COBRA plan or when COBRA coverage terminates may convert to conversion coverage within 30 days of the termination of coverage date until you are age 65.

EARLY RETIREMENT

If you retire early, you may continue to be enrolled in PEHP until age 65, subject to payment of the required premiums.

MEDICARE SUPPLEMENT

You or your dependents are eligible to convert to the PEHP Medicare Supplement Plan upon reaching age 65, if you are no longer working, and you were previously covered under the group policy. Contact PEHP for the applicable enrollment deadlines.

DISABILITY PREMIUM WAIVER

If you are approved for a benefit under the PEHP Disability Program or for an employer sponsored long-term disability program, you will have your premium waived beginning two months after your last day worked up to a 22-month period, after which you will have the option of enrolling in a COBRA policy.

claims submission

The primary purpose of any group medical plan is protection. An illness or injury can cause serious financial problems unless there is protection in the form of medical coverage. PEHP is created to protect employees and their families from those worries.

WHEN YOU HAVE A CLAIM

When you use a Preferred Provider, the provider will submit your claims directly to PEHP. Claims from Preferred Providers will always have benefits made payable directly to the Preferred Provider.

When you use a non-preferred provider, it is your responsibility to see that your claim is filed promptly and properly. PEHP accepts claims submitted electronically. Claims that are not received within 24 months from the date of service will be denied.

1. If you are in doubt about a charge, consult PEHP. Be prepared to give the CPT and HCPCS code (obtain from your provider) and the providefs charge. Remember, any charges above the PESB are your responsibility.
2. Regardless of services provided by the provider, PEHP will only be responsible for eligible benefits so make certain only necessary services are provided.
3. Be sure you have obtained pre-authorization, if required, and that you understand and agree to all services performed.

Preparing a claim for PEHP

1. Present your Identification/Prescription card at your first visit.
2. The provider will have a release form for you to sign which authorizes PEHP to obtain information if necessary. Be sure to sign this form.
3. If you and your provider want benefits paid directly to the provider, sign the authorization form allowing PEHP to do so.
4. If your provider prefers to submit claims on PEHP claim forms, you may obtain them from your payroll coordinator or PEHP.

Claims Submission (continued)

5. If services are related to an accident, list the accident details, when, where, and how the injury occurred.
6. If you are covered by another insurance policy, be sure to provide PEHP with the following information: The name and social security number of the policyholder, the employer, group number, and name and address of the insurance carrier.

If PEHP is the primary carrier, your claim will be considered by PEHP first. You should keep a copy of the itemized claim and send it, along with PEHP's explanation of benefits, to your secondary carrier.

If PEHP is the secondary carrier, your claim will be considered by PEHP after the primary carrier. You must send us a copy of the primary carrier's explanation of benefits along with a copy of the itemized bills.

If you or your dependent receives medical care in another country, benefits will be payable on the same basis as in a local setting; however, it is your responsibility to translate the claim into English and convert the charges to US. currency. Be sure to include a copy of the original foreign claim along with a PEHP claim form.

Claims should be mailed to:

Public Employees Health Program
Claims Division
560 East ***200*** South
Salt Lake City, Utah ***84102-2004***

WHEN YOU NEED INFORMATION

As a result of the Utah Information Practices Act, PEHP must identify an insured calling for claims information. Please sign the designated area on the claim form to allow us to give healthcare providers information necessary to pay your claim.

CLAIMS REVIEW AND APPEALS PROCESS

If you feel one of your claims has been denied inappropriately, you may request a full and fair review by writing to the Medical Review Board within ***60*** days after you receive notice of denial. Requests for review of claims should be mailed to:

Medical Review Board
Public Employees Health Program
560 East 200 South
Salt Lake City, Utah ***84102-2004***

If you disagree with the decision or action taken by the Medical Review Board, you have the right to an appeal process as contained in Section ***49-1-610*** of the Utah Code. You may contact the Utah State Retirement Board for details.

Charges for medical records necessary for claims review are your responsibility.

PRE-AUTHORIZATION OF BENEFITS

Pre-authorization is the administrative process whereby you and your provider can learn, in advance of treatment, the level of benefits provided by the policy for the proposed treatment plan.

Pre-authorization is required for certain specified benefits of PEHP which may be subject to limitations and to receive the maximum benefits of the policy for hospitalization, surgical procedures, durable medical equipment, or other services as required. Written pre-authorization is recommended to assure complete and accurate information is provided by all parties.

Pre-authorization does not guarantee payment should coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should the actual circumstances of the services be different than originally submitted.

multiple coverage

When two insurance companies are involved, claims will take longer to process. You can speed up the process by submitting all necessary information to both carriers.

COORDINATION OF BENEFITS

The State plans contain a non-profit provision to coordinate with other plans under which an insured is covered so that the total benefits available will not exceed 100% of the allowable expenses. An allowable expense is any necessary, reasonable and customary expense covered, at least in part, by one of the plans. When a claim is made, the ***primary*** plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses or 100% of the charges. No plan pays more than it would without the coordination provision. When coordinating as secondary with a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Medicare, PEHP will only cover the copayments that the insured is legally obligated to pay.

It is the responsibility of the insured to provide complete and accurate information regarding other coverage(s) and to be sure benefits are coordinated in the proper order. The insured should notify the PEHP office if the status of other group coverage terminates or changes.

To avoid inaccurate coordination of benefits, the Identification/Prescription card will list only those insureds for which PEHP is primary carrier.

When coordinating benefits for dependent children, the plan of the spouse whose birthday (regardless of the year of birth) is earliest in the calendar year is primary according to Utah regulations.

If the insurance carrier with which PEHP coordinates has not implemented the birthday guideline, the coordination will be conducted under the following guidelines:

1. The plan covering the patient directly rather than as an employee's dependent is primary and the other plan is secondary.
2. If a child is covered under both parents' plans, the father's is primary.
3. If neither (1) nor (2) applies, the plan covering the patient longest is primary.
4. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. first, the plan of the parent with custody of the child;
   b. then, the plan of the spouse of the parent with custody of the child; and
   c. finally, the plan of the parent not having custody of the child.
   d. Exception: if there is a court decree establishing financial responsibility for the child's healthcare expenses on one parent and that parent's program is aware of the terms of such decree, the responsible parent's program Will be primary to any other dependent coverage. A copy of the divorce decree may be requested for file documentation.

When you have coverage under two group policies, it is very important to keep duplicate copies of all bills or information submitted to your primary carrier. Upon receipt of payment or rejection of submitted charges from your primary carrier, attach copies of the original bills to the Explanation of Benefits form received from your primary carrier and submit them for consideration to your Secondary carrier. When submitting claims for prescription drug copayments from another insurance plan, it is necessary to attach the receipt to a PEHP drug claim form. PEHP will reimburse the copayment or the PEHP allowance, whichever is less.

Any charges for services or supplies that are provided by any governmental plan or law under which the insured is or could be covered, including workers compensation. are excluded by this plan.

COORDINATION WITH MEDICARE

PEHP's coordination of benefits with Medicare and its status as primary or secondary payor with regards to Medicare will be determined in accordance with applicable Medicare laws and regulations. Benefits will be considered payable by Medicare for purposes of this provision when you are eligible for Medicare benefits and have enrolled in or applied for benefits under Medicare Parts A or B, or would have received benefits payable by Medicare if you had taken action required by Medicare to qualify for benefits, such as receiving services in a facility to which Medicare would have paid benefits.

When PEHP is secondary to Medicare, benefits otherwise payable under PEHP will he reduced so that the sum of benefits payable under PEHP and Medicare will not exceed the total of such allowable expenses.

Multiple Coverage *(continued)*

NO-FAULT AUTO INSURANCE

Any benefits payable under automobile insurance such as No-Fault, Personal Injury Protection, or similar coverage will be denied by PEHP. All such auto insurance benefits payable on behalf of you or your dependents will be considered, even if such coverage exceeds the statutory minimum required coverage.

Written documentation is required to verify full benefits paid by auto insurance.

If an insured does not have the No-Fault insurance required by state law and PEHP is required to pay benefits that would otherwise be payable under the required No-Fault coverage, PEHP or its assignees shall have the right to recover from the insured the amount of benefits paid.

SUBROGATION

In the event that benefits described herein are furnished to you or your dependent for bodily injury caused by a third party, the PEHP will be subrogated (substituted) with respect to your right or your dependent's right (to the extent of the value of the benefits paid) to any claim against such third party causing such bodily injury. Your acceptance of payment of benefits will constitute such subrogation, and you will be required to execute and deliver at PEHP's request such additional evidence as may be required from time to time. Your failure to execute such evidence as may be required will make you liable to the PEHP for all costs and expenses previously incurred by PEHP in your behalf or your dependent's behalf because of such bodily injury. Regardless of whether the insured has been "made whole" or has not been fully compensated for the injury, PEHP has a contractual subrogation right.

exclusions

HOSPITAL EXCLUSIONS

1. Hospital charges in conjunction with ineligible surgical procedures or related complications.
2. Charges for treatment programs for enuresis (bed wetting) or encopresis.
3. Convenience items such as guest trays, cots, and telephone calls.
4. Occupational therapy except as defined under Limitations.
5. Recreational therapy.
6. Whole blood.
7. Autologous (self) blood storage for future use.
8. Hospital charges while on leave-of-absence.
9. Charges incurred as an organ or tissue donor except when in conjundion with an eligible transplant where both recipient and donor are covered by PEHP.
10. Charges for custodial care.
11. Charges for nutritional counseling
12. Charges for care, confinement, or services in a transitional living facility. community reintegration program, vocational rehabilitation, or services to re-train self-care or activities of daily living

SURGERY EXCLUSIONS

1. Breast reconstruction, augmentation, or implant: except initial restoration made necessary as a result of cancer surgery performed in the preceding five years.
2. Capsulotomy, replacement, or repair of breast implant originally placed for cosmetic purposes, or any other complication of cosmetic or non-covered breast surgery.
3. Simple/subcutaneous mastectomy for benign disease or mastectomy for anything other than cancer, including reconstruction or complications.
4. Obesity surgery, such as gastric bypass, stomach stapling etc., including any present or future complications.
5. Cosmetic surgery.
6. Assisted Reproductive Technologies (ART's) including but not limited to Invitro Fertilization, Gamete Intra Fallopian Tube Transfer (GIFT), Embryo Transfer (ET), Zygote Intra Fallopian Transfer (ZIFT), or the storing of frozen sperm, eggs, or gametes for future use.

Exclusions (continued)

7. Radial keratotomy, astigmatic keratotomy or other surgical treatment for correction of refractive errors.
8. Transplants without pre-authorization.
9. Charges incurred as an organ or tissue donor except when in conjunction with an eligible transplant where both recipient and donor are covered by PEHP.
10. Organ or tissue transplant (except cornea, kidney, liver, bone marrow, stem cell, lung and heart, which may be considered with written pre-authorization).
11. Reversal of sterilization.
12. Trans-sexual operations.
13. Rhytidectomy (excision of wrinkles around the eyes).
14. Charges that are dental in origin: extraction of teeth, dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, or orthodontia, including anesthesia or supplies used in such care.
15. Complications as a result of other non-covered or ineligible surgery.
16. Injection of collagen.
17. Lipectomy, abdominoplasty, pannulectomy.
18. Repair of diastasis recti.
19. Non-FDA approved, experimental, or investigational procedures, drugs, and devices.
20. Pellet implantation.
21. Liposuction.
22. Chemical peel.
23. Charges in excess of the global fee as a result of changing providers during the course of pregnancy for other than documented medical necessity.
24. Charges for the treatment of weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.
25. Orthodontic treatment or expansion appliance in conjunction with jaw surgery.
26. Chin implant. genioplasty or horizontal symphyseal osteotomy.
27. Unbundling or fragmentation of surgical codes.
28. Injections of sclerosing solution for spider veins.
29. Rhinoplasty, except as a result of accidental injury in the preceding five years.
30. Laser assisted uvulopalotoplasty (LAUP).
31. Additional surgical fees are not eligible when a laser is used.

ANESTHESIA EXCLUSIONS

1. Anesthesia charges in conjunction with ineligible surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care (standby) except in conjunction with procedure #92982, angioplasty.

MEDICAL VISITS EXCLUSIONS

1. Eye glasses, and contact lenses (with exception of one lens immediately following corneal transplant surgery or the contact lens necessary to treat keratoconus).
2. Eye exams or refractions, except as covered under Prevention Plus. Glaucoma exams are payable only if symptomatology is present.
3. Examinations made in connection with a hearing aid.
4. Hormone injections or pellet implants (an allowance up to $300 may be approved for injections when oral medication cannot be used). Office visits in conjunction with hormone injections are not eligible.
5. Charges for weight loss or in conjunction with weight loss programs.
6. Charges for medical hospital visits the same day or following a surgical procedure.
7. Charges for office visits in conjunction with allergy injection.
8. Health screenings or services to rule out familial diseases or conditions without manifest symptoms.
9. Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.
10. Charges for nutritional counseling or analysis.
11. Charges for Candida/candidiasis.
12. Charges for any injection when the material used is not identified.
13. Speech therapy, except as described under Limitations.
14. Hypnotherapy or biofeedback.
15. Chiropractic or physical therapy primarily for maintenance care.
16. Injectable vitamins or their administration.
17. Experimental, investigational, or unproven medical practices.
18. Vision therapy.
19. Tobacco abuse
20. Take-home medications from a provider's office.
21. Treatment therapies for developmental delay or child developmental programs.

Exclusions (continued)

22. Sublingual antigens.
23. Rolfing or massage therapy.
24. Hair transplants or other treatment for hair loss or restoration.
25. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD, or myofacial pain.
26. Care, treatment, or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
27. Charges for prolotherapy or chelation therapy.
28. Office calls in conjunction with repetitive therapeutic injections.
29. Charges for routine exams and well child care, except as covered under Prevention Plus.
30. Charges for medical visits for pregnancy prior to delivery. Pregnancy is a global fee benefit payable at the time of delivery and coverage must continue through delivery to be eligible. (See COBRA for continuation of coverage after termination.)
31. Functional or work capacity evaluations, impairment ratings, work hardening programs, or back school.
32. Medical or psychological evaluations for legal purposes such as custodial rights, paternity suits, disability ratings, etc., or for insurance or employment examinations.
33. Charges for special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's practice.
34. Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise program.
35. Charges for sublingual or colorimetric testing.
36. Charges which are dental in origin including care and treatment of the teeth, gums or alveolar process, endodontia, periodontia, orthodontia, prosthetics, dental implants, or anesthesia or supplies used in such care.
37. Charges for flu shots, except as covered under Prevention Plus.
38. Chages for pre-natal classes.
39. Charges for the treatment of weak, strained, flat, or unstable feet; visits in connection with orthotics; palliative care or metatarsalgia or bunions; treatment for corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.

LAB AND X-RAYS EXCLUSIONS

1. Charges in conjundion with routine physical examinations and well child care, except as covered under Prevention Plus.
2. Charges in connection with weight loss programs.
3. Health screenings or services to rule out familial diseases or conditions without manifest symptoms are considered routine and are excluded from coverage.
4. Genetic screening except prenatal amniocentesis or chorionic villi sampling or as described in the Pre-Authorization Section above.
5. Over utilization or services which are not medically necessary to treat a condition as determined by the PEHP medical review process.
6. Charges incurred as an organ or tissue donor except when in conjunction with an eligible transplant where both recipient and donor are covered by PEHP.
7. Charges for sublingual or colorimetric testing.
8. Charges for Candida/candidiasis.
9. Unbundling of lab charges. Most multiple labs can be done in "panels" and will be paid accordingly.
10. Lab, x-ray, or diagnostic services which are unproven, experimental, or investigational.
11. Charges for hair analysis, trace elements, or dental filling toxicity.
12. Charges in conjunction with ineligible procedures, including pre-or post-operative evaluation.
13. Routine drug screening.
14. Routine HIV/AIDS testing.
15. Routine screening for osteoporosis, except as provided through Prevention PLUS.
16. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

AMBULANCE

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.

Exclusions (continued)

HOME HEALTH AND HOSPICE EXCLUSIONS

1. Nursing or aide services which are requested for your convenience or the convenience of your family, (i.e., bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter) which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not payable. This exclusion applies regardless of whether services were recommended by a provider.
2. Private duty nursing, home health aide.
3. Custodial care.
4. Respite care.
5. Travel or transportation expenses, escort services, or food services.

ADOPTION EXCLUSIONS

1. Charges for the adoption of nieces, nephews, brothers, sisters, cousins, grandchildren, or stepchildren.
2. Charges for transportation, travel expenses, accommodations, passport fees, translation fees, photos, postage, etc.
3. Charges for living expenses, food, and/or counseling for the natural mother.

MENTAL HEALTH AND SUBSTANCE ABUSE EXCLUSIONS

1. Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.
2. Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
3. Office calls in conjunction with repetitive therapeutic injections.
4. Charges in conjunction with wilderness programs.
5. Inpatient charges for behavior modification, enuresis, or encopresis.
6. Inpatient treatment for mental health and/or substance abuse which is not pre-authorized will not be payable.
7. Psychological evaluations for legal purposes such as custodial rights, etc.
8. Occupational or recreational therapy.
9. Hospital charges while on leave of absence.

DURABLE MEDICAL EQUIPMENT EXCLUSIONS

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

1. Routine maintenance and care, cleaning solutions, batteries, tires, upholstery repair, etc., of Durable Medical Equipment (DME) or prosthetics.
2. Maintenance, warranty, or service contracts.
3. Charges for training and testing in conjunction with DME or prosthetics.
4. Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.
5. Air conditioning.
6. Home physical therapy kits.
7. Whirlpool baths and other multipurpose equipment or facilities, health spas, swimming pools, saunas, or exercise equipment.
8. Air filtration units, vaporizers, humidifiers.
9. Heating lamps or pads.
10. Charges for a continuous hypothermia machine, cold therapy, or ice packs.
11. Lift or contour chairs, vibrating chairs, or adjustable beds.
12. Dialysis equipment.
13. Orthotics, arch supports, shoe inserts or wedges, etc.
14. Orthopedic or corrective shoes. (Attachment of a brace or crossbar is eligible).
15. Hearing aids.
16. Adaptive devices used to assist with activities of daily living, vocational or life skills.
17. Communicative equipment or devices, systems, or components.
18. Computerized assistive devices; communicative boards, etc.
19. Breast pumps.
20. Vitamins, minerals, food supplements, special infant formulas, or homeopathic medicine.
21. Blood pressure monitors.
22. Wrist alarms for diabetics.
23. Enuresis alarm systems.

Exclusions (continued)

24. Spinal pelvic stabilizers.
25. Orthopedic braces solely for sports activities.
26. More than one breast prosthesis for each affected breast following surgery for breast cancer.
27. More than one lens for each affected eye following corneal transplant surgery.
28. More than two pair of support hose for a medical diagnosis per policy year.
29. Computer systems or components.
30. Environmental control devices, i.e., light switches, telephones, etc.
31. Replacement of lost, damaged, or stolen DME or prosthetics.
32. Eye glasses/contact lenses (except as described in Limitations Section).

PHARMACY EXCLUSIONS

The fact that a provider may prescribe, order, recommend, or approve a prescription drug, service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

1. Drugs that are not medically necessary for condition.
2. Charges for the treatment of hair loss or restoration (Rogaine).
3. Experimental or investigational drugs.
4. Anorexiants/diet aids (with the exception of Dexedrine/Desoxyn/Obetrol for documented treatment of Attention Deficient Disorder in children under age 18).
5. Any over-the-counter (OTC) drugs or drugs that do not require a prescription, except insulin.
6. Any drug not FDA approved.
7. Therapeutic devices or appliances.
8. Diagnostic agents
9. Immunization agents, biological serum, blood, or blood plasma.
10. Prescriptions which an eligible person is entitled to receive from any governmental plan or medication prescribed as a result of an industrial injury or illness payable under Workers Cornpensation or employer's liability laws.
11. Medications taken by you or your dependents while in an institution which operates on its premises a facility for dispensing pharmaceuticals.

12. Any drug used for cosmetic purposes.
13. Drugs used by a second party.
14. Compounded drugs (a procedure that alters the FDA approved form of a legend drug.)
15. The cost of any quantity of medication dispensed in excess of a consecutive 100-day supply.
16. Replacement prescriptions resulting from loss, theft or breakage.
17. Prescription refills that have not been used by at least 70% according to the provider's direction.
18. Prescriptions filled or refilled before the effective date of coverage, or after termination date of coverage, even if prescribed while you are covered by PEHP.
19. Delivery or shipping charges.
20. Medication furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
21. Vitamins, minerals, food supplements, or homeopathic medicine.
22. Mother's milk or special infant formulas.
23. Anabolic steroids (Used for muscle building)
24. Medication prescribed as a result of an industrial (on the job) injury or illness payable under Worker's Compensation or employer's liability laws.
25. PEHP may require that all prescription drugs, services, or supplies be authorized through a Primary Care Physician and/or case manager to be eligible.

GENERAL EXCLUSIONS

1. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by PEHP.
2. Charges for educational material, literature, or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illness such as diabetes.
3. Charges for physical exams and well-child care, including lab and x-ray, except as covered under Prevention Plus.
4. Charges for services primarily for convenience, contentment, or other non-therapeutic purpose.
5. Charges which are for unnecessary care or treatment, or which are in excess of PESB or PCF.
6. Charges for excessive care or over utilization, not medically necessary to treat the condition, as determined by the PEHP review process.

Exclusions (continued)

7. Charges for unproven medical practices or care, treatment, or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
8. Charges for services without adequate diagnosis or dates of service.
9. Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.
10. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.
11. Charges which the insured is not, in absence of coverage, legally obligated to pay.
12. Charges for services, treatments, or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
13. Charges for services or supplies received as a result of an act of war occurring when the insured is covered by PEHP.
14. Shipping, handling, or finance charges.
15. Charges for medical care rendered by an immediate family member are subject to review by PEHP and may be determined by PEHP to be ineligible.
16. Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which, is payable under workman's compensation or employer's liability laws.
17. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
18. Charges on claims submitted more than 24 months after service has been rendered.
19. Charges for expenses in connection with appointments scheduled and not kept.
20. Charges for telephone calls or consultations.
21. Charges made for completion or submission of insurance forms.

This is only a partial list of the general exclusions. For other exclusions, please see the specific benefit section and contact PEHP for a review of the Master Policy.

plan definitions

TRADITIONAL/PREFERRED CARE

Ambulatory Surgical Facility
Any public or private establishment with an organized medical staff of physicians, licensed and JCAHO (Joint Commission for Accreditation of Healthcare Organizations) accredited, and/or Medicare certified with permanent facilities equipped and operated primarily for the purpose of performing ambulatory surgical procedures and with continuous physician services whenever an insured is in the facility but does not provide services or other accommodations for insureds to stay overnight.

Assignment of Benefits
A procedure whereby an insured authorizes PEHP to make payment directly to the provider of any eligible benefits.

Certification and Disclosure of Coverage
A certificate describing an individual's Creditable Coverage. PEHP must provide this Certificate and Disclosure to an insured when they cease to be covered under PEHP. Certification and Disclosure shall specify any waiting periods imposed on an individual for any coverage. A Certification and Disclosure of Coverage must be presented to PEHP at the time a new hire and/or dependent is enrolled in PEHP.

Coordination of Benefits (COB)
The coordination of eligible benefits between two or more group plans under which an individual is covered after primary and secondary coverage determination is made.

Copayment
Amount paid by an insured for their share for an eligible service. Payments by an insured for charges which are not eligible are not included within the meaning of copayment and do not apply to yearly out-of-pocket limits.

Cosmetic Surgery
Any surgical procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function.

Creditable Coverage
Any comprehensive insurance coverage a new enrollee had prior to enrolling in PEHP. This prior coverage will be applied to reduce any pre-existing exclusion PEHP may impose. If there has been a lapse in coverage of 63-days or more, any creditable coverage will not apply.

Plan Definitions *(continued)*

Custodial Care
Services, supplies, or accommodations for care rendered which:

1. Do not provide treatment of injury or sickness;
2. Could be provided by persons without professional skills or qualifications;
3. Are provided primarily to assist an insured in daily living;
4. Are for convenience, contentment, or other non-therapeutic purposes;
5. Maintains physical condition when there is no prospect of affecting remission or restoration of the insured to a condition in which care would be required.

Dependents
An employee's spouse and unmarried children, including legally adopted children, to age 26 who are dependent upon and have a parental relationship with the employee. Dependent does not include an unborn fetus. Dependent may include a child over age 26 who is totally incapacitated.

Designated Service Plan (DSP)
A program of global fees negotiated between PEHP and specific providers for all necessary medical and surgical services related to a specific condition or procedure. Copayrnents are reduced under global fees.

Elective Surgery
A non-emergency surgery that can be scheduled 48 hours after diagnosis.

Eligible Benefit
The payment for medical expenses made on behalf of an insured under the Master Policy. PEHP will pay the applicable percentage outlined in the policy, which exceed the deductible or copayment, up to the maximum benefit shown in the PESB.

Emergency Care
Care provided for the sudden and unexpected onset of a condition requiring medical or surgical care necessary to safeguard the insured's life immediately after onset of the emergency. A determination of emergency will be made on the basis of the final diagnosis.

Employee
An employer's employee who is eligible for coverage in the Group Insurance Program of Title 49, Chapter 8 of the Utah Code Annotated.

Employer
The State, its educational institutions and political subdivisions that are eligible to participate and have elected to participate in the Group Insurance Program of Title 49, Chapter 8 of the Utah Code Annotated.

Enrollment
The process of making written application for coverage through PEHP, subject to specified time periods and policy provisions.

Enrollment Date
The date of enrollment of the individual in the plan or if earlier the first day of the waiting period for such enrollment.

Exclusions
Those services or supplies incurred by the insured which are not considered eligible under this policy.

Experimental, Investigational, or Unproven
Those services or supplies which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as determined by PEHP or which have not received FDA approval.

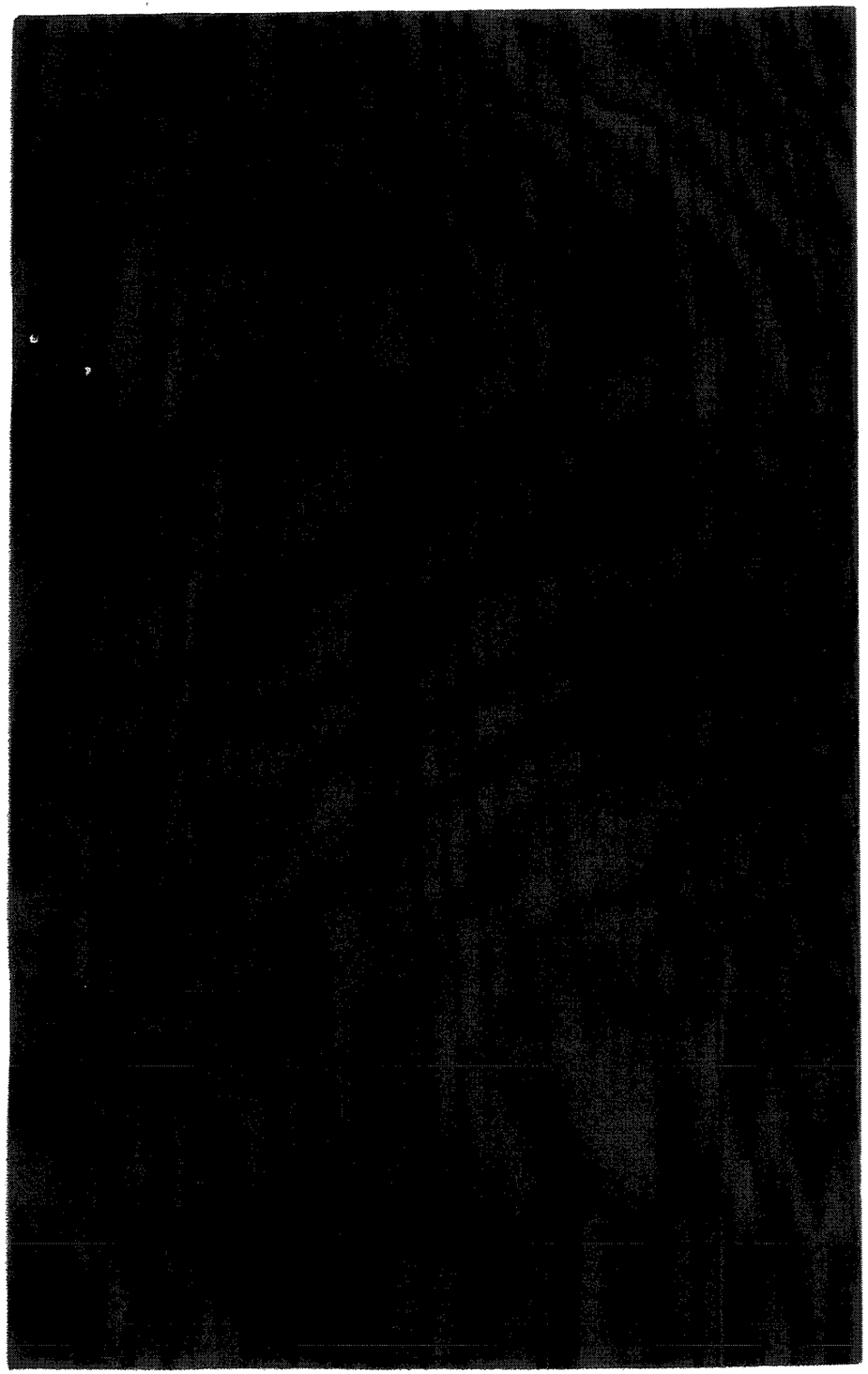
Hospice Care
A program of supportive care that addresses the spiritual, social, and psychological needs of terminally ill insureds and their families.

Hospital

1. An institution which is accredited as a hospital under the JCAHO (Joint Commission for Accreditation of Healthcare Organizations);
2. Any other institution which is operated pursuant to law, under the supervision of a staff of physicians and with twenty-four hour per day nursing service, which is primarily engaged in providing:
   a. General inpatient medical care and treatment of ill and injured persons through medical, diagnostic, and major surgical facilities, all of which must be provided on its premises or under its control: or
   b. Specialized inpatient medical care and treatment of ill or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises. under its control, or through a written agreement with a hospital (as defined above), or with a specialized provider of those facilities.

In no event will the term "hospital" include a facility operated primarily as an outpatient or free-standing unit, or a convalescent nursing home, or an institution or part thereof which is used principally as a convalescent, rest, or nursing facility or facility for the aged, or which primarily furnishes domiciliary or custodial care, including training in the routines of daily living, or which is operated primarily as a school. Skilled nursing facilities will only be included in this definition if the stay is in lieu of a hospital stay, subject to medical case management.

index



Plan Definitions *(continued)*

Industrial Claim
An illness or injury arising out of or in the course of employment.

Inpatient
When a person has been assigned to a bed in the hospital other than in the outpatient department and a charge for room and board has been made.

Insured
An employee or dependent as defined in Title *49,* Chapter 8 of the Utah Code Annotated, or individuals who have converted to COBRA coverage, conversion coverage, or a retired individual who is eligible for coverage and has continued to pay premiums.

Life-Threatening
The sudden and acute onset of an injury or illness where delay in treatment would jeopardize the insured's life or cause permanent damage to his health such as, but not limited to, loss of heartbeat, loss of consciousness, convulsions, stopped or severely obstructed breathing, food poisoning, massive and uncontrolled bleeding, or marked increase in temperature. A determination of life-threatening will be made on the basis of the final diagnosis.

Medical Case Management
The active involvement by request of PEHP of a nurse coordinator working with the insured and provider(s) to coordinate a comprehensive, medically appropriate treatment plan with prudent use of benefit dollars.

Medically Necessary
Any healthcare services, supplies, or treatment provided for an illness or injury which is consistent with the insured's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of an insured, provider, hospital, or other provider. However, such healthcare services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the insured's condition or the quality of medical care the insured received as determined by established medical review mechanisms, within the scope of the physician's licensure, and/or consistent with and included in policies established and recognized by PEHP.

Mental Health
Any diagnosis described under Mental Disorders in the ICD.9 book (International Classification of Diseases) except those which are otherwise excluded from coverage under the Master Policy. Pain management for chronic or non-acute illness will be considered under mental health.

PCF (Preferred Care Fees)
A schedule of allowable fees established by PEHP and accepted by Preferred Providers.

PESB (Public Employees Schedule of Benefits)
Schedule of allowable amounts established by PEHP for specified eligible benefits on a policy year basis for a service, procedure, treatment, or device.

Parental Relationship
The relationship between a natural child or stepchild and a parent while the child or stepchild is dependent on the parent for insurance. Example — the stepfather has coverage on a child then divorces the child's natural mother. The stepfather no longer has a parental relationship with the child.

Pre-Existing Condition
Any injury, illness. or condition which was diagnosed or treated within the six-month period prior to the insured's enrollment date. Benefits for such a condition will not be payable until the insured has been covered for a period of nine months.

Preferred Provider
Any provider who has contracted with PEHP to serve as a Preferred Provider.

Provider
A licensed practitioner of the healing arts acting within the scope of the provider's practice.

Surgical Procedure or Surgery
Cutting, suturing, treating bums, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping, (paracentesis). applying plaster casts, administering pneumothorax, or endoscopy.

Unbundling
The practice of using numerous CPT codes to identify procedures that are included in a single code (also known as "fragmentation," "exploding," or "a la carte" medicine).

Waiting Period
The period of time that must pass, with respect to the individual and/or dependents, before the individual is eligible to be covered for benefits under the terms of the plan.